

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>ALBERT A. ALBRIGHT</b>			2a. DATE OF DEATH Month <b>07</b> Day <b>15</b> Year <b>68</b>		2b. HOUR <b>1:50 P</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>12-12-91</b>		6. AGE (In years last birthday) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>ALLEGANY</b> Md.		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RETIRED Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>LA VALE, MD.</b>	13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>LA VALE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>529 B. ST. LA VALE</b>	
14. FATHER'S NAME <b>ALBERT</b>	15. MOTHER'S MAIDEN NAME <b>SALLY SMITH</b>	16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <b>214-07-4831</b>		17. INFORMANT <b>HOSPITAL RECORD</b> Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause, per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>uremia</b> <b>403 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>chronic nephritis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>1 year</b> <b>2 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>446 X</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>L. Brings</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>7-15-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>L. Brings, M.D.</b>		22e. ADDRESS <b>57 Greene St., Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>July 18, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>		
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			
ROY W ANDERSON						Month Day Year 7-22-68 19 10:45 am			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD
male	white	Apr 16, 1887		81 YRS.					Month Day Year 11:30 am
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH			
Pennsylvania		U.S.A.		WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegheny		Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland			Memorial Hospital--DOA			Retired glass worker		Anchor-Hocking Glass Corp.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Penna			Fayette		Indian Head		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		None
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Marion Anderson			Elizabeth Johnson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no			162-14-2318		James A. Anderson Melcroft, Pa. 15462				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) RUPTURED HEART-----									Sudden
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) CRUSHED CHEST									"
DUE TO, OR AS A CONSEQUENCE OF									
(c) (AUTOMOBILE ACCIDENT)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
7254									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			10:45 p.m. July 22, 1968		Driver of auto involved in Accident				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		U.S. Route #40		Four miles East Flintstone, Alleg. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Benedict Skitarelic			M.D.			July 22, 1968			
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		July 25, 1968		Mt. Tabor Cem.		Springfield Twp. Fayette Co. Pa.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
25 Lee Sileon Cumberland, Md.						DATE JUL 25 1968		Charles Judge	

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# FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED		2b. HOUR	
CAROLYN SUE ANTHONY						JULY 6 1968		8 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD		2d. HOUR	
FEMALE	WHITE	OCT. 13, 1967	8 YRS	23		JULY 6, 1968		8 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
WASHINGTON, D.C.		U.S.A.				ALLEGANY			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
FROSTBURG			170 CENTRE STREET			N.A.		N.A.	
13a. USUAL RESIDENCE (Where deceased lived; if institutional, give address before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND			PRINCE GEORGE'S			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
			SUITLAND					3232 SYCAMORE LANE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
HARRY G. ANTHONY			SANDRA N. DUNCAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
N.A.			N.A.			SUITLAND, MD. MRS. HARRY ANTHONY, SYCAMORE LANE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:								CONGENITAL	
IMMEDIATE CAUSE (a) 7467									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) (CONGENITAL)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
7544									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		JULY 6, 1968			
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.		ADDRESS (Street, city, town, or county)		CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		7/6/68		FROSTBURG MEM. PARK		FROSTBURG, ALLEGANY, MD.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
MILTON M. SOWERS		JUL - 9 1968		f Charles Judge					
HOME, 60 W. MAIN, FROSTBURG									



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1. *Journal of the American Medical Association*, 1997; 277: 1001-1005.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09250											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Harvey</b>						2a. DATE OF DEATH <b>7</b> Month <b>27</b> Day <b>68</b> Year		2b. HOUR <b>9:55 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 1885</b>		6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Europe</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Sacred Heart Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Teacher</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Self.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>696 Thompson Ave.</b>	
14. FATHER'S NAME First <b>Harris</b> Middle <b>Aronson</b> Last <b>Aronson</b>			15. MOTHER'S MAIDEN NAME First <b>Ethel</b> Middle <b>Ethel</b> Last <b>(Unknown)</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give year or date of service) <b>WW I</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Mrs. Harold Marx, 696 Thompson Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardiovascular Disease</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>7-27-68</b> , 19 <b>68</b> , to <b>7-28-68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7-27-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John E. Seamus</b>			22c. DATE SIGNED <b>7-28-68</b>			22d. PHYSICIAN'S NAME (Type) <b>John E. Seamus</b>			22e. ADDRESS		
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7/29/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>East View Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland MD</b>		
24. FUNERAL DIRECTOR <b>Louis Allen Inc.</b>			ADDRESS <b>Cumb. MD</b>			25a. REC'D BY REGISTRAR <b>JUL 30 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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HEALTH DEPT.**

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR	
Florence Ethel Baker						7-31-68		1:30p M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Female	White	May 7, 1890	78 YRS			July 31, 1968		1:30p M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Allegany			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland			Cumberland Nursing and Convalescent Home			Retired Nurse		Memorial Hosp	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Allegany		Cumberland	YES	403 Caroline St.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
No			214-05-5931		William R. Kohl, 3 ***		403 Caroline St. Cumberland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism									Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 887X									26 Days
(b) Fracture of Left Hip									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
9040 Fracture of Left Hip									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			10:00am 7-5-68 19		Fell at home				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
		Home		403 Caroline Street, Cumberland, Alleg. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			July 31, 1968			
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		8/3/68		Hillcrest Burial Park		Near Cumberland Alleg Md			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles E. Hoyer			230 Balto Ave. Cumberland Md			AUG 5 1968		Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

09252

1 DECEASED-NAME (Type or print) <b>CHARLES HENRY BALES</b>			2a. DATE OF DEATH Month <b>JULY</b> Day <b>30</b> Year <b>1968</b>			2b. HOUR <b>9:30</b> M			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>July 31, 1887</b>		6 AGE (In years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Berkeley Co., W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>606 Maryland Avenue</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Carman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>R.R.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>606 Maryland Avenue</b>	
14 FATHER'S NAME First <b>Henry</b> Middle <b>Bales</b> Last <b>Clara</b>			15. MOTHER'S MAIDEN NAME First <b>Clara</b> Middle <b>Henry</b> Last <b>Henry</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>C. Nelson Bales</b>		Address <b>124 W. South St. Martinsburg, W. Va.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinomatous</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>5 yrs</b> (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b> <b>16 yrs</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>177</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>May 15, 1968</b> , to <b>July 31, 1968</b> , that (I) (we) lost the deceased alive on <b>July 31, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Clara Bales</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/30/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Cumberland, Maryland</b>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 2, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Martinsburg Berkeley W. Va.</b>			
24. FUNERAL DIRECTOR <b>Brown Funeral Home-Martinsburg, W. Va. 25401</b>				25a. REC'D BY REGISTRAR <b>Howard R. Brown</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

09252

1. DECEASED-NAME (Type or print)		First <b>EVELYNE</b>		Middle <b>R.</b>		Last <b>BECK</b>		2a. DATE OF DEATH Month <b>JULY</b> Day <b>27</b> , Year <b>1968</b>		2b. HOUR <b>A</b> MIN. <b>5:15</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MAY 5, 1923</b>		6. AGE (In years lost birthday) <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7a. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL, CUMB., MD.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					
13a. USCA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND, X</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1908 BEDFORD ST.</b>			
14. FATHER'S NAME First <b>ROBERT</b> Middle _____ Last <b>ISOM</b>		15. MOTHER'S MAIDEN NAME First _____ Middle <b>MILDRED</b> Last <b>IRWIN</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>215-18-8705</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute leukemia</u> DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>50/60</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mon.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>204.3</u>											
19a. DATE OF OPERATION <u>204.3</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.) _____		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1968</u> to <u>July 27, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 26, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>W. R. Hodges</u>		22d. PHYSICIAN'S NAME (Type) <b>DR. R. HODGES</b>		22e. ADDRESS <b>122 SO. CENTRE ST., CUMBERLAND, MD.</b>		22c. DATE SIGNED <u>7/28/68</u>					
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 30, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>					
24. FUNERAL DIRECTOR <b>H. Lee Silcox 404 Decatur St., Cumb., Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 31 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



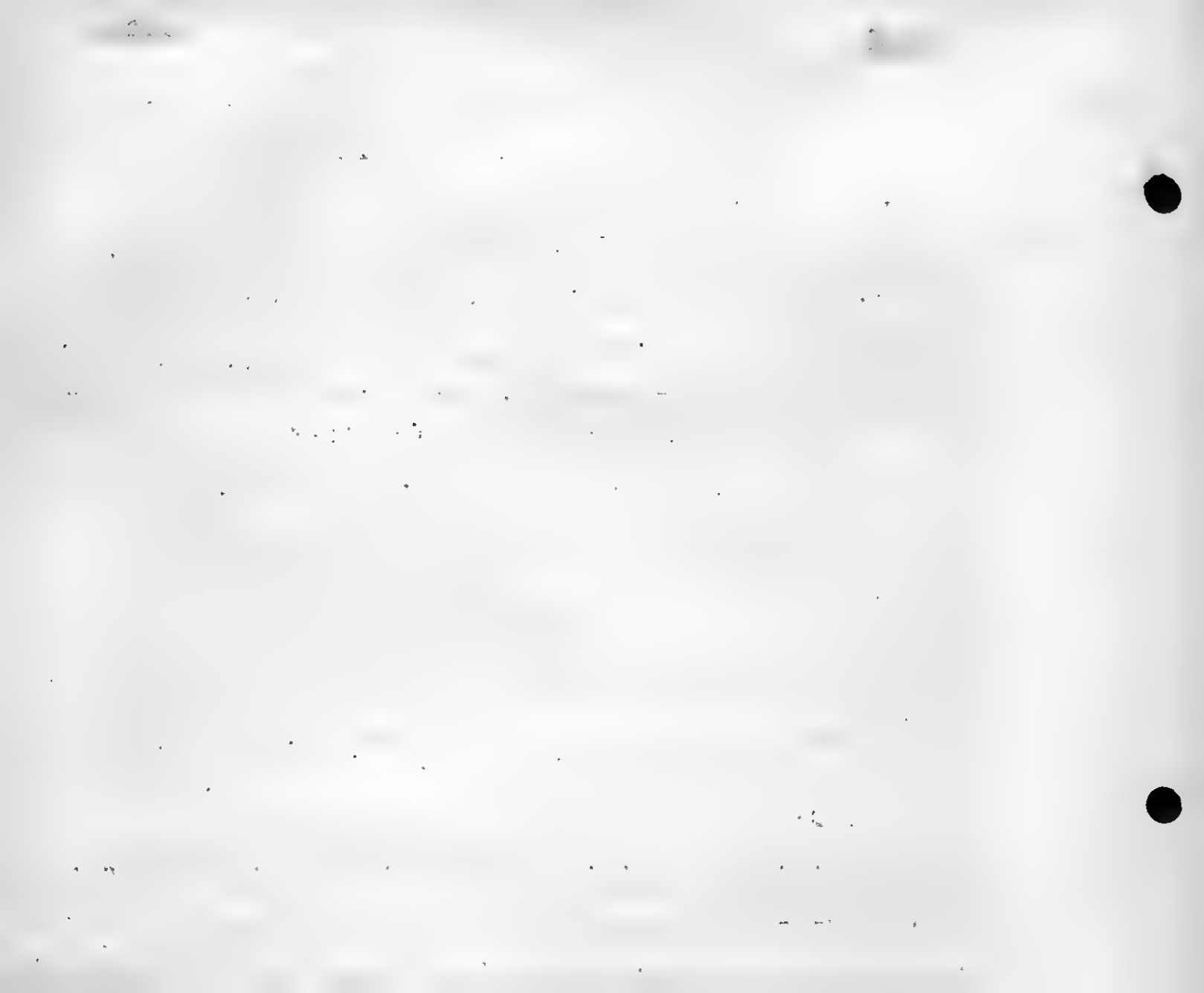


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09254  
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>FRANK</b>		First Middle Last <b>BENNETT</b>		2a. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>1968</b>		2b. HOUR <b>A</b> <b>4:20</b> M	
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>November 3, 1890</b>		6. AGE (in years lost birthday) <b>77</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegheny</b> Md.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CUMBERLAND NURSING HOME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED BENNETT TRANS. COMPANY</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Allegheny</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>801 Edgewood Drive</b>		14. FATHER'S NAME First <b>Alonzo</b> Middle <b>Bennett</b> Last <b>Potts</b>		15. MOTHER'S MAIDEN NAME First <b>Annie</b> Middle <b>Potts</b> Last <b>Potts</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. <b>211-32-3709</b>		17. INFORMANT <b>Mrs. Theoda Bennett</b>		Address <b>801 Edgewood Drive Cumberland, Maryland</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Conjunctive Heart failure on</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>basin of a far advanced A.S.L.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Since 1967.</b>							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>7.2.1</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>9-20-1967</b> to <b>7-8-1968</b> , that (I) (we) last saw the deceased alive on <b>7-7-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.							
22b. SIGNATURE <b>Wm. F. Williams</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7-8-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Wm. F. Williams, M. D.</b>		22e. ADDRESS <b>122 S. Centre St., Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-11-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegheny Maryland</b>	
24. FUNERAL DIRECTOR <b>H. Lee Silcox</b>		ADDRESS <b>404 Decatur St., Cumb., Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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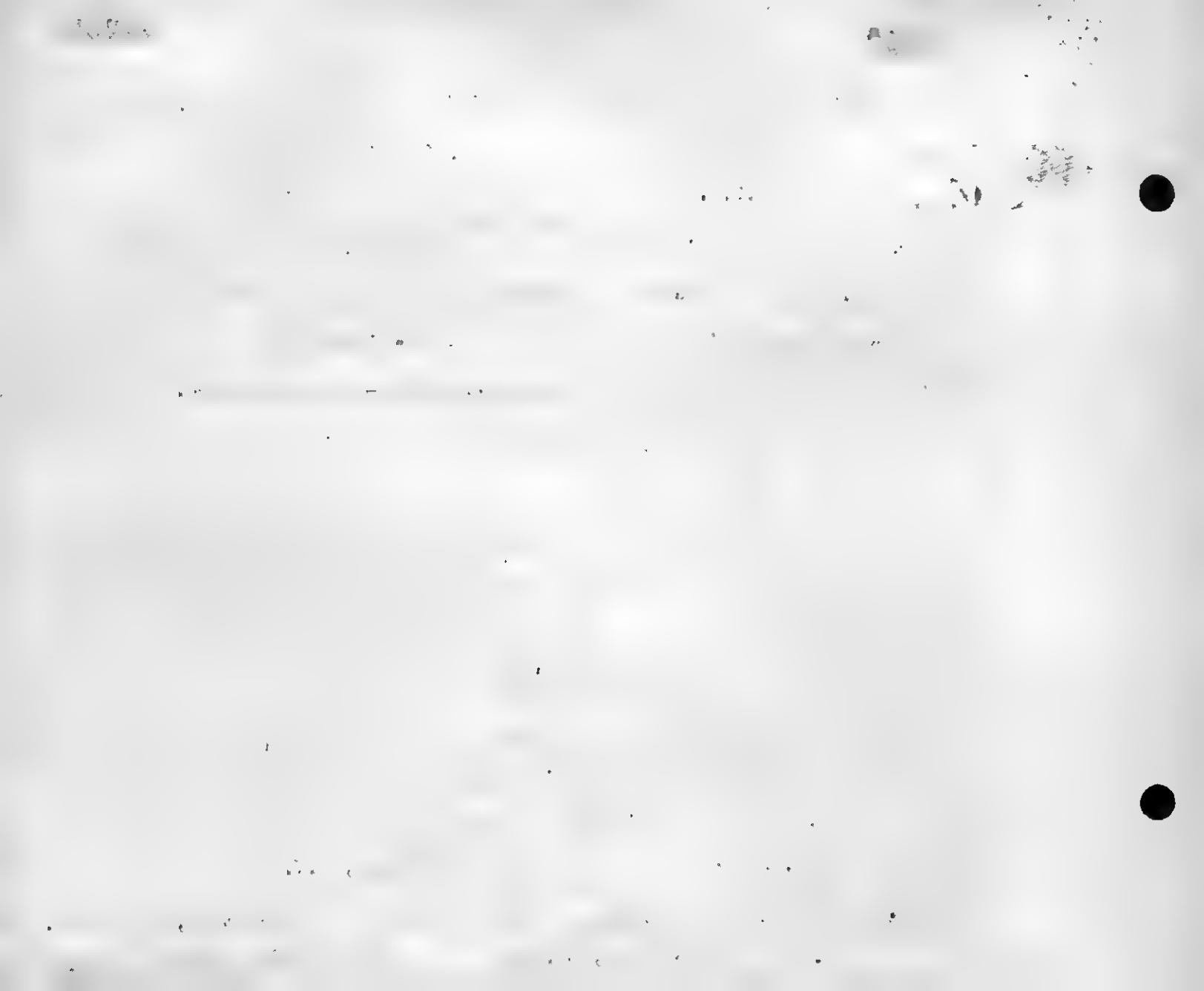
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

09255

1. DECEASED-NAME (Type or print) <b>Anna</b>			First <b>Daisy</b>			Middle <b>Berisford</b>			Last			2a. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1968</b>			2b. HOUR <b>12 24M</b>		
3 SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Oct. 12, 1873</b>			6. AGE (In years last birthday) <b>94</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Allegany</b> Md.								
10. CITY OR TOWN OF DEATH <b>Westernport</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>115 Church</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Teacher</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Music</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>Westernport</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>115 Church</b>					
14. FATHER'S NAME First <b>Thomas</b> Middle <b>Berisford</b> Last						15. MOTHER'S MAIDEN NAME First <b>Katherine</b> Middle <b>McGovernon</b> Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)						16b. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Edmund Getty-Westernport, Md.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>428X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4222</b> <b>Arteriosclerosis</b>																	
19a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>None</b>											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 12</b> , 19 <b>65</b> , to <b>July 19</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>July 18</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Paul R. Wilson M.D.</b>						DEGREE <b>M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>July 19, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson</b>						22e. ADDRESS <b>Piedmont, W. Va.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>7/22/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>			23d. LOCATION (City or Town) (County) (State) <b>Westernport, Md.</b>								
24. FUNERAL DIRECTOR <b>E. J. Pava</b>						ADDRESS <b>Westernport, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>JUL 22 1968</b>			25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>					

MEDICAL CERTIFICATION





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
10M REV 1 68

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09256

1 DECEASED NAME (Type or Print) <b>John Jay Bobo</b>		First Middle Last		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>July 26, 1968</b>		2b HOUR <b>10:00 A.M.</b>	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>Sept. 24, 1903</b>	6 AGE (1 - years last b. <b>64</b> YRS)	7 IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	8 IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	2c DATE PRONOUNCED DEAD Month <b>July</b> Day <b>26</b> , Year <b>1968</b>	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Allegany</b>	
10 CITY OR TOWN OF DEATH <b>Rt. # 1 Cumberland,</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Valley Rd.</b>		12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>Inspector</b>		12b KIND OF BUSINESS OR INDUSTRY <b>W. Md. Rwy</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Allegany</b>		13c CITY OR TOWN <b>Cumberland,</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME <b>Robert L.</b>		First Middle Last <b>Bobo</b>		15 MOTHER'S MAIDEN NAME <b>Angeline</b>		First Middle Last <b>-- Halterman</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b SOCIAL SECURITY NO (If yes give war or dates of service) <b>705-10-7315</b>		17. INFORMANT ADDRESS <b>Mrs. Madelyn E. Bobo, Rt. # 1 Cumberland, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CORONARY SCLEROSIS WITH THROMBOSIS --</b> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No		City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <b>July 26, 1968</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>7/29/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park,</b>		23d LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Maryland</b>		25a REC'D BY REGISTRAR DATE <b>JUL 30 1968</b>	
				25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 11  
304 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09257  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First WILHELMINA	Middle A.	Last BRANT	2a. DATE OF DEATH JULY 8, 1968		2b. HOUR 1:00 PM
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH APRIL 8, 1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) CUMB., MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL, CITY		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME MORTZFELDT, ERNEST		15 MOTHER'S MAIDEN NAME ELIZABETH RASCHKE		13e. STREET AND NUMBER 907 SHADES LANE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 219-56-9672		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>chronic negative septicaemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cholera</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic cholecystitis &amp; lithiasis</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic perineal abscess for cancer</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>DR. F. MILTENBERGER</i> PHYSICIAN'S NAME (Type) DR. F. MILTENBERGER				22c. DATE SIGNED		22d. ADDRESS 122 SO. CENTRE ST., CUMBERLAND,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/10/68		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland, Maryland 21502				25a. REC'D BY REGISTRAR JUL 11 1968		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



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Page 4 may be retained by the hospital or attending physician.

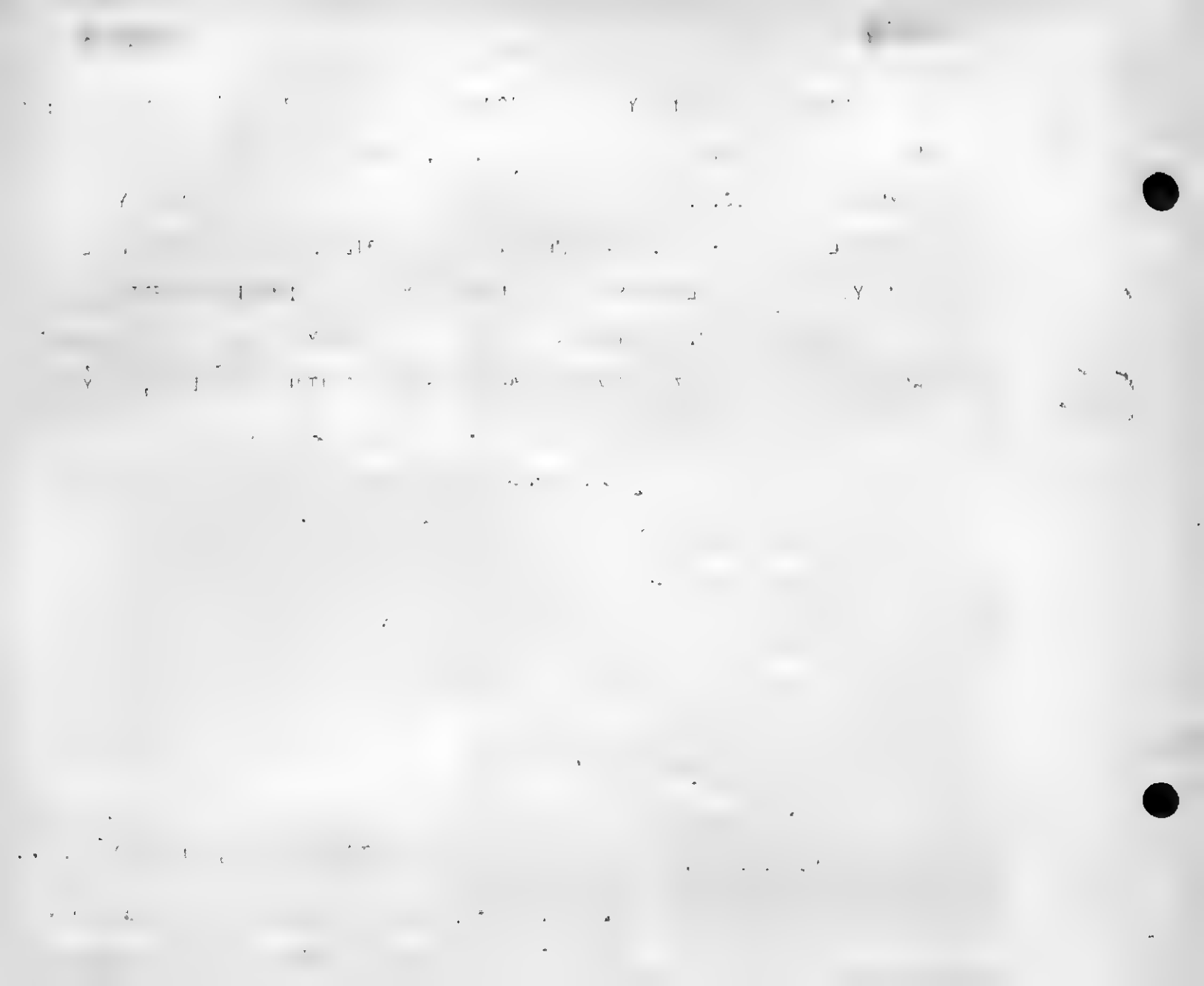
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

09258

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
RALPH				HENRY	BREIGNER	7 14 68			5:37 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		OCT. 25, 1905		62 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
MARYLAND		U.S.A.				ALLEGANY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		SACRED HEART HOSPITAL		RAILROAD-CARMAN		RAILROAD					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. CITY OR TOWN		13c. INS. DE. CITY LIMITS?		13e. STREET AND NUMBER					
MARYLAND		ALLEGANY		CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5 HUMBERD STREET			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
MARTIN				J.	BREIGNER	MARY			BLOOM	BREIGNER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			900 AUSTIN DRIVE, SACRED HEART HOSPITAL CUMBERLAND, MARYLAND		
NO			705 05 4568								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Coronary Artery Disease</u>									yrs.		
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Diabetes Mellitus</u>									yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Chronic Lung Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>5/15, 1968</u> to <u>7/14, 1968</u> , that (I) (we) last saw the deceased alive on <u>7/14, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
<u>[Signature]</u>						7/15/68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
DR. J. A. PAGAN						5 POTOMAC STREET, RIDGELEY, W. VA.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		July 17, 1968		Hillcrest Burial Park		Cumberland		Allegany		Md.	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.						JUL 18 1968		<u>[Signature]</u>			





FOR STATE  
HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) <b>Theodore Marshall Brinkman</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>July</b> Day <b>6</b> Year <b>1968</b>		2b. HOUR <b>8:15 AM</b>			
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 30, 1888</b>		6. AGE (in years last birthday) <b>84 YRS</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Allegany</b>		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Tin Mill Worker</b>			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>1022 Virginia Avenue</b>	
14. FATHER'S NAME First <b>Frederick</b> Middle <b>William</b> Last <b>Brinkman</b>						15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Slider</b> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO <b>214-05-9330</b>		17. INFORMANT ADDRESS <b>Mrs. Dorothy Brinkman 1022 Va. Ave. Cumb'd Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>CORONARY SCLEROSIS</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS <b>---</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7x</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS. STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <b>CUMBERLAND, MARYLAND</b>					
22b. DATE SIGNED <b>July 6, 1968</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/ 9/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem. Mausoleum</b>				23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md.</b>			
24. FUNERAL DIRECTOR <b>Charles E. Hafer</b> ADDRESS <b>Charles E. Hafer, 230 Balto Ave. Cumberland Md.</b>						25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09260	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
William		E.		Britton				ESTIMATED <input type="checkbox"/> Month Day Year JULY 15 1968		? M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR
Male	White	Dec. 13, 1909		58 YRS	MONTHS DAYS		HOURS MIN		Month Day Year July 23 1968		12: P M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Allegany Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland				215 Virginia Ave.				Retired Maintenance		State Road	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		215 Virginia Ave.			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
First Middle Last William Britton				First Middle Last Louise Gottz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
no						Daughter Mrs. Josephine Parker, Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										CORONARY OCCLUSION	
4109 DUE TO, OR AS A CONSEQUENCE OF										SUDDEN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										CORONARY SCLEROSIS	
(b) DUE TO, OR AS A CONSEQUENCE OF										---	
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
426											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		July 23, 1968			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
								CUMBERLAND, MARYLAND			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		July 24, 1968		Rose Hill Cemetery		Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR ADDRESS						25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.						JUL 26 1968		Charles Judge			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban permits, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

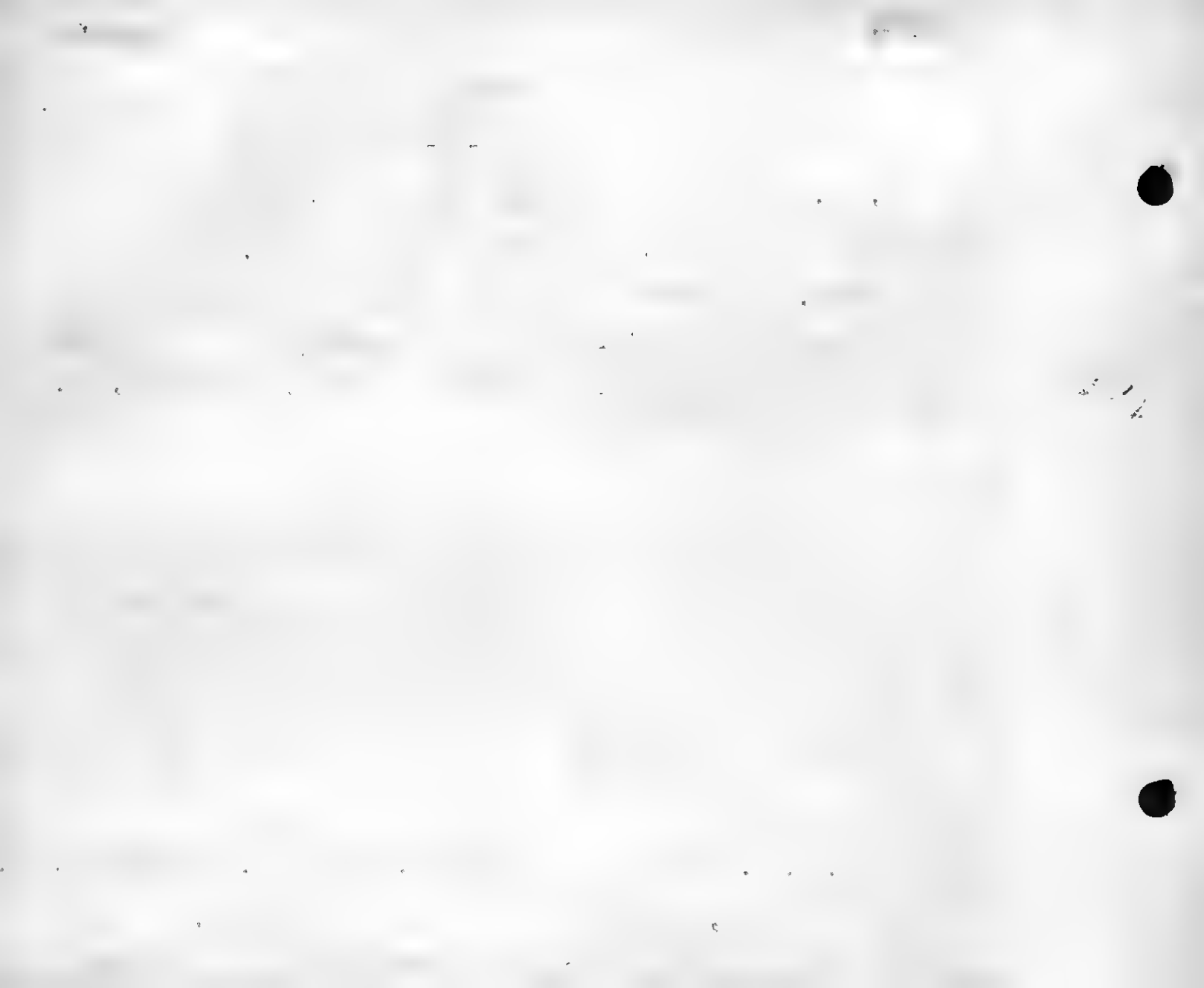
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Theodore H. Bugg						Month	Day	Year	4:15 PM
3. SEX	4 RACE		5 DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.
Male	White		8/3/1896			71 YRS.		MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Illinois		U. S. A.				Allegany County Md			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland			Allegany County Infirmary			Retired: B & O. R.R.		Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Md.			Allegany		Cumberland		510 Eastern Ave.		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First
Joseph Bugg						Anna Dashney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address
Unknown			705-09-3467			P.O. Box 599, Allegany County Infirmary records.			Cumberland, Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Brain aneurysm</i> <i>approx. 5 days</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerosis</i> <i>many years</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chl. A S H D</i> <i>many years</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<i>Emphysema. Spinal deformities. Fr. R. hip 6/20/68</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(Enter nature of injury in Part 1 or Part 2, Item 18)			
		HOUR A.M. Month Day Year							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		Street or R.F.D. No City or Town County State			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		Street or R.F.D. No		City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 28, 1967</i> , to <i>July 12, 1968</i> , that (I) (we) lost saw the deceased alive on <i>July 11, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	
<i>John A. Topper</i>								22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
<i>John A. Topper</i>						<i>Memorial Hospital</i>		<i>Cumberland Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		July 14, 1968		Sunset Memorial Park		Cumberland Allegany Maryland			
24 FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
H. Lee Silcox 404 Decatur St., Cumb., Md.						JUL 15 1968		<i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09262	
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First <b>VIOLET</b>		Middle		Last <b>BURKETT</b>		2a. DATE OF DEATH Month Day Year <b>JULY 13 1968</b>		2b. HOUR PM <b>5:49</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>8-18-1887</b>		6 AGE (in years last birthday) <b>80 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>KEGG, PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HWFE.</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>PENNA.</b>		13b. COUNTY <b>BEDFORD</b>		13c. CITY OR TOWN <b>HYNDMAN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14 FATHER'S NAME First Middle Last <b>ANDREW HILB GAS</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Zebeltass Hoon</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>No</b>							
16b. SOCIAL SECURITY NO <b>210-18-9580</b>		17 INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Terminal cardiac failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>H. and A.S. Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sen. arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>443X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>13 Dec., 1967</b> , to <b>13 Aug., 1968</b> , that (I) (we) last saw the deceased alive on <b>13 Aug., 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W. Alfred Van Ormer</b>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>		22e. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 16, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Palo Alto Cemetery</b>		23d. LOCATION (City or Town) <b>Hyndman, Pa.</b>		(County) <b>RD#1 Bedford</b>		(State) <b>Co.</b>	
24. FUNERAL DIRECTOR <b>Harvey H. Zeigler, Hyndman, Pa.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUL 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09260	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR
MELISSA			ANN		CANFIELD				<input checked="" type="checkbox"/> Month Day Year July 3, 1968		4:45 a.m.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	7. UNDER 1 YEAR		8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR
Female	White	April 15, 1980		88 YRS	MONTHS DAYS HOURS MIN				Month Day Year July 3, 1968		4:45 a.m.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		
West Virginia			U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany		Cumberland		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
223 Baltimore Avenue			Housewife								
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Allegany			Cumberland			223 Baltimore Avenue		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last Monterville J. Bright			First Middle Last Amelia C. Irons								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			213-24-7401			Mrs. Evelyn Fells, 223 Balto. Ave., Cumb., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										CORONARY OCCLUSION	
4109										SUDDEN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										CORONARY SCLEROSIS	
(b)										--	
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				July 3, 1968			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		7-5-68		Meadowridge Cemetery		Baltimore, Md.					
24. FUNERAL DIRECTOR <i>Charles E. Hafer</i>				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Charles E. Hafer, 230 Balto. Ave., Cumberland, Md.				JUL - 8 1968				<i>g Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09264											
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH		2b. TIME				
JAMES S. CASTLE SR.					JULY 3, 1968		10:30				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR			
MALE		WHITE		9-5-1898		69 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MD.		U. S. A.				ALLEGANY Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSP.			Retired Machinist			Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTRY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.			ALLEGANY			CUMBERLAND		YES		518 AVONDALE AVE.,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
WILLIAM L. CASTLE			CORA G. MYERS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
						MEMORIAL HOSPITAL - CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Coronary Arteriosclerosis</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Arteriosclerosis</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial Infarction</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4.2.1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from June 26, 1968, to July 3, 1968, that (I) (we) last saw the deceased alive on July 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death											
22b. SIGNATURE		22c. DATE SIGNED									
<i>Dr. Blane Schindler</i>		JULY 4, 1968									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
DR. BLANE SCHINDLER		43 GREENE ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town)		(County)		(State)	
Burial		July 6, 1968		St. Mary's Cemetery		Cumberland, Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.						JUL - 8 1968		<i>Charles Judge</i>			





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

09265

1. DECEASED-NAME (Type or print) <b>EMMA BELLE CHANEY</b>			2a. DATE OF DEATH Month <b>JULY</b> Day <b>2</b> Year <b>1968</b>		2b. HOUR <b>6:04</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>1-28-1876</b>		6. AGE (In years last birthday) <b>92</b> YRS	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HWFE.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>CUMBERLAND</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>36 LAING AVE.</b>
14. FATHER'S NAME First <b>HENRY</b> Middle <b>WILLISON</b> Last <b>BOFFET</b>		15. MOTHER'S MAIDEN NAME First <b>REBECCA</b> Middle <b>BOFFET</b> Last <b>BOFFET</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>3. X</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 2, 1968</b> to <b>July 2, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/4/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. B. SCHINDLER</b>		22e. ADDRESS <b>CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 5, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Ashby Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Fort Ashby, W. Va.</b>	
24. FUNERAL DIRECTOR <b>James P. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

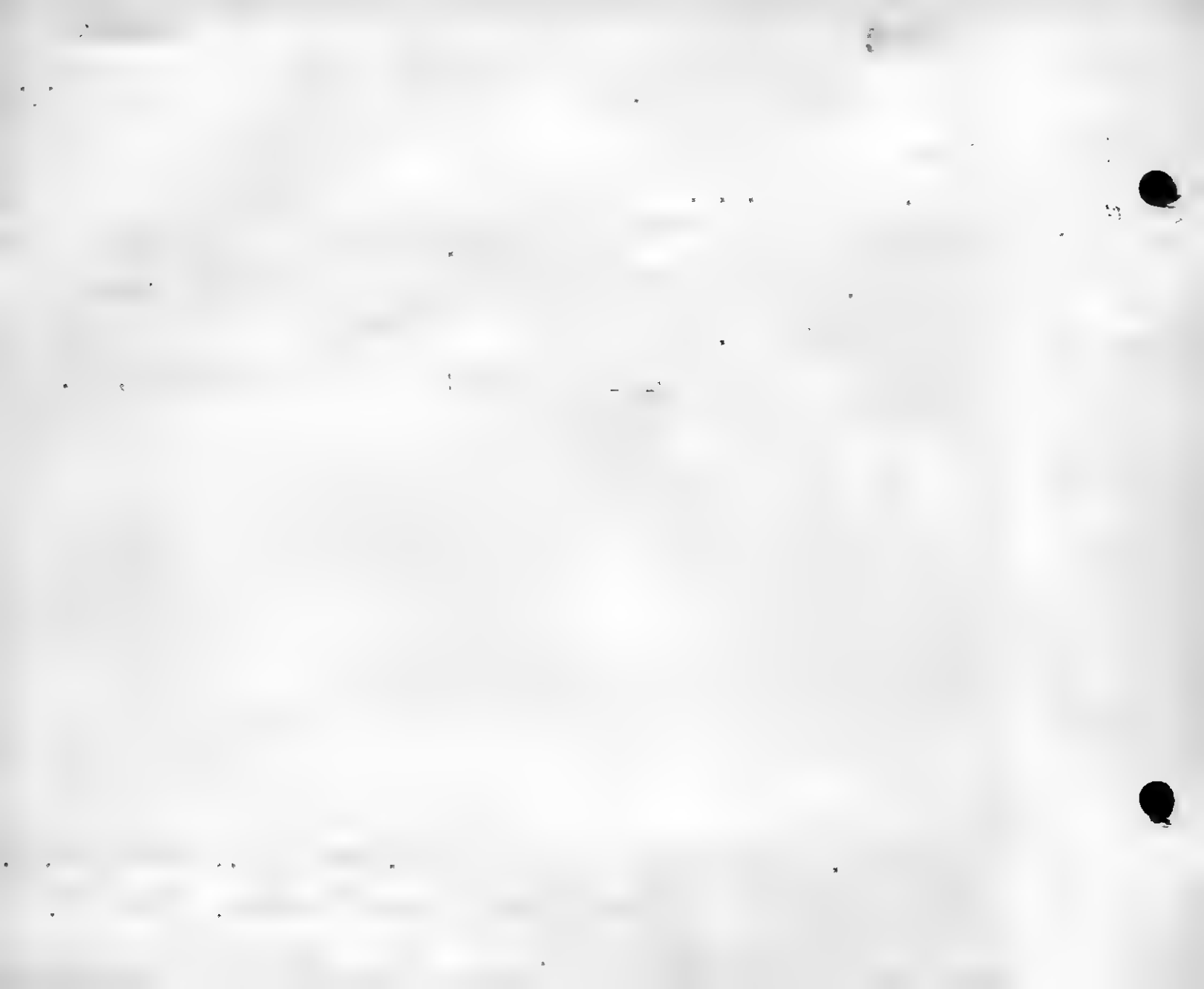


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09266			
258													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First <b>THOMAS</b>		Middle <b>RALPH</b>		Last <b>CROYLE</b>		2a. DATE OF DEATH Month <b>7</b> , Day <b>3</b> , Year <b>1968</b>		A. HOUR <b>10:25</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>10-5-1897</b>			6 AGE (in years last birthday) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b>			Md.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Porter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Celaneose Fibre</b>				
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>MD.</b>			13b. COUNTY <b>ALLEGANY</b>			13c. CITY OR TOWN <b>LA VALE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>NATIONAL HIGHWAY</b>			
14. FATHER'S NAME First <b>GEORGE</b> Middle <b>A.</b> Last <b>CROYLE</b>			15. MOTHER'S MAIDEN NAME First <b>MARGARET</b> Middle <b>DIVELY</b> Last <b>DIVELY</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No.</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>214-07-4619</b>			17. INFORMANT Address <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial ischemia, severe</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary embolism</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1</b> <b>2 days</b> <b>7 yrs</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4109</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>7-3</b> , 19 <b>68</b> , to <b>7-3</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>7-3</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>V. P. Dross</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>7-5-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>DR. VINCENT DROSS</b>						22e. ADDRESS <b>456 N. CENTRE ST., CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVING BODY <b>Burial</b>			23b. DATE <b>7/6/68</b>		23c. NAME OF CEMETERY C CREMATORY <b>Osterburg Reformed Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Bedford, Pa.</b>					
24. FUNERAL DIRECTOR <b>H. Wayne George</b>						ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>DAIUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

MEDICAL CERTIFICATION

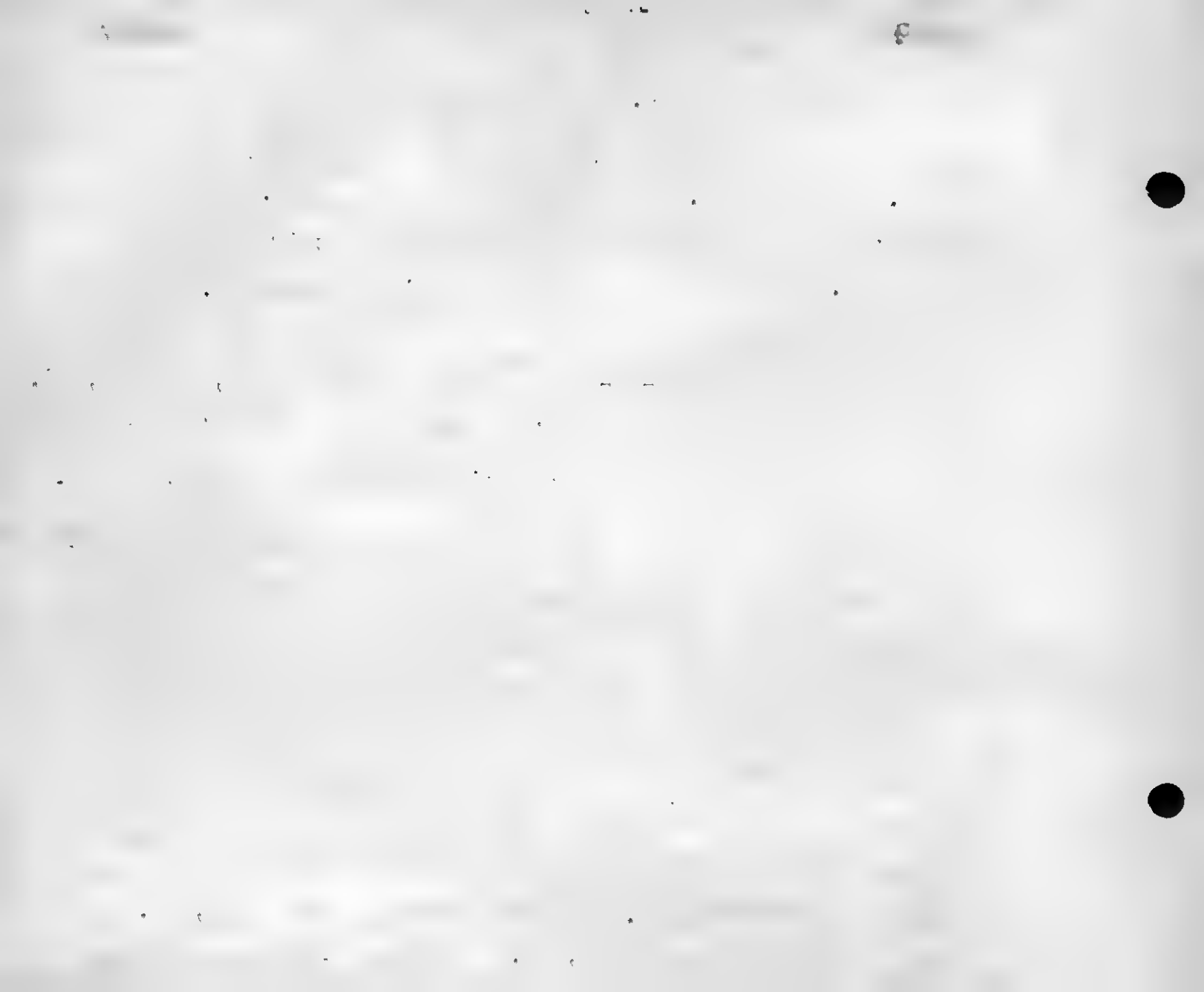


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-8. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09267			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH			2b. HOUR	
Michael			J.		Cunningham					JULY 8, 1968		1:35 P.M.	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		White		5/21/1893		75 YRS.		MONTHS DAYS HOURS MIN.		July 8, 1968		1:35 P.M.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
MD.			USA.						Allegany			Md	
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland				Sacred Heart Hospital				Retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?	
MD.				County				Midland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER				14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Main St.				John Cunningham				Mary Ann Murphy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17 INFORMANT				ADDRESS	
Yes				War # 1				214-32-3217				Bridget Cunningham, Midland, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										(WIFE)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:										SHOCK; EXANGUINATION		30 Minutes	
IMMEDIATE CAUSE (a)													
DUE TO, OR AS A CONSEQUENCE OF										GASTRIC CARCINOMA WITH HEMORRHAGE		-----	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b)		(Duration of carcinoma not known)	
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)													
151													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
				P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				Benedict Skitarelic, M.D.				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				BENEDICT SKITARELIC, M.D.				JULY 8, 1968					
				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county)				CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
Burial				7/11/1968				St. Michaels Cemetery					
								23d. LOCATION (City or Town) (County) (State)					
								Frostburg, Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR					
GEORGE EICHHORN				Lonaconing, Md.				JUL 11 1968					
								25b. REGISTRAR'S SIGNATURE					
								Charles Judge					



## CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month		2b. TIME	
JOHN WILLIAM		JOHN	WILLIAM	DEFFINBAUGH	JULY 18, 1968		7:30 PM	
3. SEX	MALE		4 RACE	WHITE		5. DATE OF BIRTH	7-12-94	
7a. BIRTHPLACE (State or foreign country)	W. VA.		7b. CITIZEN OF WHAT COUNTRY?	U. S. A.		6. AGE (In years lost birthday)	74 YRS.	
8. MARRIED	WIDOWED		NEVER MARRIED		DIVORCED		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH	CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address)		MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		MD.		13b. COUNTY		ALLEGANY		12b. KIND OF BUSINESS OR INDUSTRY
13c. CITY OR TOWN		OLDTOWN		13d. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
13f. COUNTY		ALLEGANY		13g. STREET AND NUMBER		None		Own Farm
14. FATHER'S NAME		First		Middle		Lost		15. MOTHER'S MAIDEN NAME
GEORGE		DEFFINBAUGH		MARTHA		V.		HESSER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		MEMORIAL HOSPITAL, CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Pneumonia</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>gen. arteriosclerosis</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic malnutrition</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type)		DR. W. P. JAMES		22e. ADDRESS		22c. DATE SIGNED		
				CUMBERLAND, MD.		7/20/68		
23a. BURIAL, CREMATION, REBURY (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BANDY (Specify)		July 20, 1968		Deffinbaugh Cemetery		Oldtown, Md. Allegany		
24. FUNERAL DIRECTOR		James F. Scarpelli, Cumberland, Md.		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
				JUL 26 1968		J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1/68

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09269

1 DECEASED NAME (Type or Print) <b>CHARLES EDWARD DETER</b>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> JULY 23, '68 3:00 A M		
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>FEB 22, 1912</b>	6 AGE (In years and birthday) <b>56</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>CUMBERLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY</b>
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>622 FREDERICK STREET</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CELANESE CORP. OF AMERICA</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admision) STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>CUMBERLAND</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME <b>CHARLES L. DETER</b>			15. MOTHER'S MAIDEN NAME <b>ELIAABETH LINDNER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO <b>217-10-5076</b>		17 INFORMANT <b>MRS HILDA DETER 622 FREDERICK ST CUMBERLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF <b>Cardiac Hypertrophy; Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30-45 Min.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21c. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>JULY 23, 1968</b>	
		ADDRESS (Street, city, town, or county) <b>CUMBERLAND, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>25 JULY 68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>FAIRVIEW BEDFORD PENNSYLVANIA</b>	
24. FUNERAL DIRECTOR <b>H. LEE SILCOX 404 DECATUR STREET CUMBERLAND MD</b>		25a. REC'D BY REGISTRAR <b>JUL 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 111 M  
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

09270

1. DECEASED NAME (Type or print)		First <b>JAMES</b>	Middle <b>P.</b>	Last <b>DEWHURST</b>	2a. DATE OF DEATH Month <b>7</b> -Day <b>3</b> -Year <b>1968</b>		Age at Death <b>11:00</b>		
3 SEX <b>MALE</b>	4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>5-26-1886</b>		6. AGE (In years last birthday) <b>82</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>MASSACHUSETTS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Dentist - Self Employed</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if in institution, Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>226 BALTIMORE AVE.,</b>	
14. FATHER'S NAME First <b>DAVID</b> Middle Last <b>DEWHURST</b>		15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>ANN</b> Last <b>WALSH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW I</b>		16b. SOCIAL SECURITY NO <b>212-38-6340</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Genitourinary infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>609X</b> Condit ions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>609X</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART 2 OTHER MARKED CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>marked anemia, generalized arteriosclerosis</b>									
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/30, 1968</b> , to <b>7-3, 1968</b> , that (I) (we) last saw the deceased alive on <b>7-3, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>Andrew Stasko M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-3-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DR. ANDREW STASKO</b>				22e. ADDRESS <b>401 DECATUR ST., CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>7/6/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosehill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>			
24. FUNERAL DIRECTOR <b>H. Lee Silcox</b>				ADDRESS <b>Cumberland, Maryland 21502</b>		25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 14 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Items 23a, c, d, Film GL03 8/5/68 km CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			2a. DATE OF DEATH			2b. HOUR			
BABY BOY DICKENS			Month 7 13 68			9:00A			
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		7-13-68		YRS.		3 53	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL							
13a. USUAL RESIDENCE (Where deceased admisson) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.		ALLEGANY		CUMBERLAND				14G JANE FRAZIER VILLAGE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT	
GARLAND		DICKENS		MARY		J. BOWERS		MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
777x						6 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7/13 1968 to 7/13 1968, that (I) (we) last saw the deceased alive on 7/13 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
DR. ROYCE HODGES				CUMBERLAND, MD.					
23a. BURIAL CREMATION, REMOVAL (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		7/18/68		Memorial Hospital		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DR. Royce Hodges		med director		DATE JUL 29 1968		J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First <b>GEENN</b>	Middle <b>W.</b>	Last <b>DIEHL</b>	2a. DATE OF DEATH Month <b>JULY</b> , Day <b>14</b> , Year <b>1968</b>		2b. HOUR <b>A</b> Min <b>3:03</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JANUARY 27, 1895</b>		6. AGE (In years last birthday) <b>73</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND,</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Conductor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Rail Road</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>610 LOUISIANA AVE.</b>	
14. FATHER'S NAME First <b>JAMES</b> Middle <b>DIEHL</b> Last <b>MAY</b>			15. MOTHER'S MAIDEN NAME First <b>FLOHR</b> Middle <b></b> Last <b></b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Yes</b>		(If yes give war or dates of service) <b>WWI</b>		16b. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Crown Artery Thrombosis</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Crown Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. <b></b> Month <b></b> Day <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Cumbersland Alleg</b>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b></b>		21f. LOCATION Street or R.F.D. No <b></b> City or Town <b></b> County <b></b> State <b></b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/1/68</b> , 19 <b>68</b> , to <b>7/1/68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7/1/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>DR. R.J. WILLIAMS</b>				DEGREE <b></b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>July 19, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>DR. R.J. WILLIAMS</b>		22e. ADDRESS <b>Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jul. 17, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md.</b>			
24. FUNERAL DIRECTOR <b>Byron Knight</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

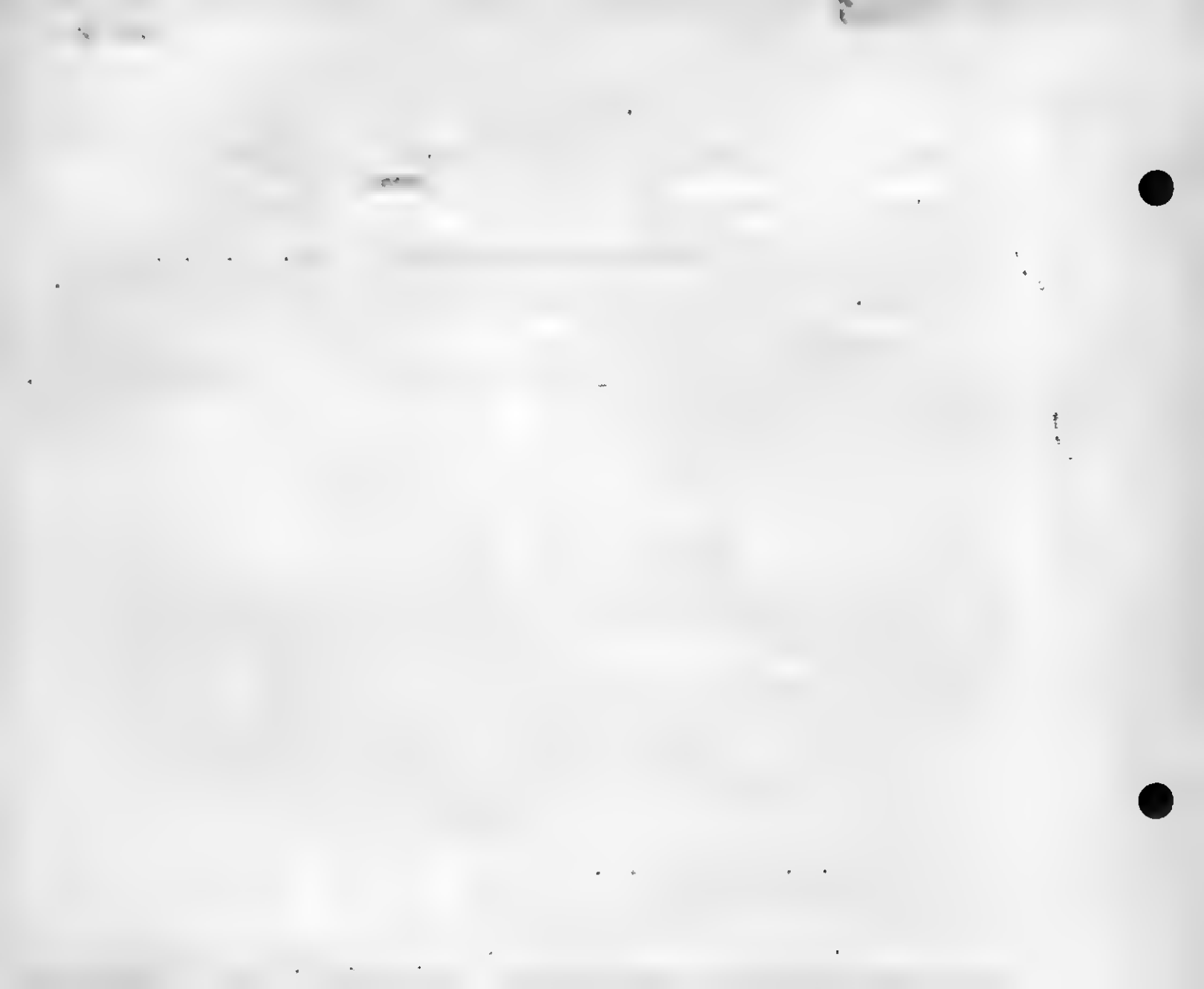




TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

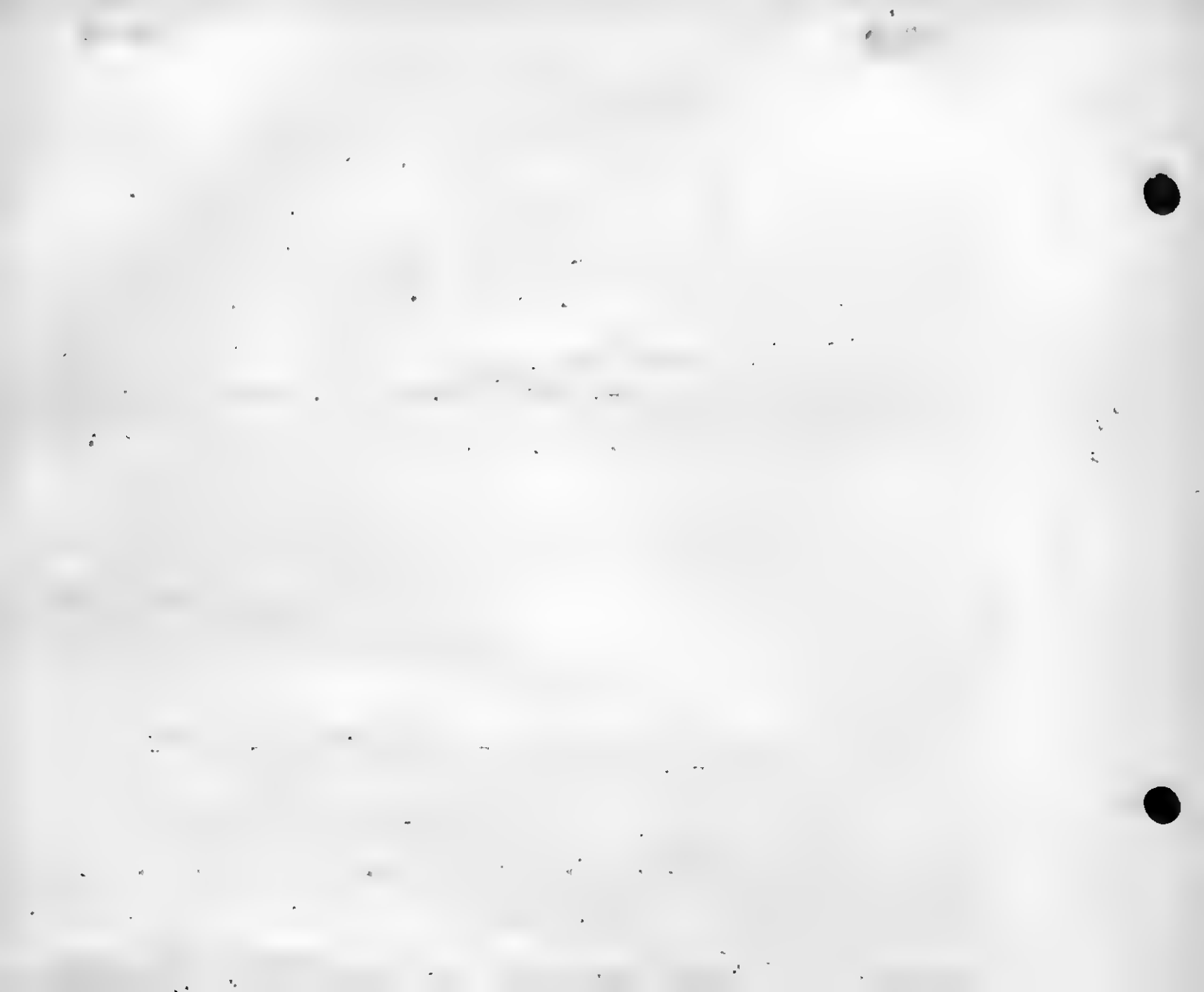
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09279
Item #6, Film G402 7/10/68 km										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>Fred Fred R. Dotson</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>1968</b>			2b. HOUR <b>205</b> M				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6-5-1882</b>		6. AGE (In years last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS <b>85</b> DAYS <b>85</b> HOURS <b>85</b> MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>America USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		COUNTY OF DEATH <b>Allegany</b>				
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cumberland Nursing Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>West. Md. R.R. Chief RD</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Foreman</b>				
13a. US-AL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1201 Frederick st.</b>		
14. FATHER'S NAME First <b>Israel</b> Middle <b>Dotson</b> Last <b>Dotson</b>			15. MOTHER'S MAIDEN NAME First <b>Jane</b> Middle <b>Dotson</b> Last <b>Dotson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>705-10-6040</b>		17. INFORMANT <b>Agnes Moon</b>		Address <b>1201 Frederick St.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>485X</b>										
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypertensive C.V.D., Diabetes Mellitus, Arteriosclerosis</b>										
19a. DATE OF OPERATION <b>4-12-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Major fracture of hip</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>4-4-1968</b> , to <b>7-2-1968</b> , that (I) (we) last saw the deceased alive on <b>7-1-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Wm. F. Williams</b>				22c. DATE SIGNED <b>7-2-68</b>						
22d. PHYSICIAN'S NAME (Type) <b>Wm. F. Williams, M. D.</b>				22e. ADDRESS <b>622 Delaplane St. Cumberland, Md.</b>						
23a. B. RIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>7/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>				
24. FUNERAL DIRECTOR <b>H. Lee Silcox</b>				ADDRESS <b>Cumberland, Md</b>		25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09274  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>Ethel Blanche Drew</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1968</b>			2b. HOUR <b>3:40AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 6, 1889</b>		6. AGE (in years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route 1, Locust Grove</b>		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>Route 1, Locust Grove</b>	
14. FATHER'S NAME First Middle Last <b>Christopher NMI Price</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Lillian NMI Kerns</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-05-4492</b>		17. INFORMANT <b>Charles W. Drew, Sr.</b>		Address <b>Cumberland Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma of cecum</b> <b>1350</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1536</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>3 - 25</b> , 19 <b>68</b> , to <b>7 - 27</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>7 - 26</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Ralph W. Ballin</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7-27-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>		22e. ADDRESS <b>62 Greene St., Cumberland, Md. 21502</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/29/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Alleg Md.</b>			
24. FUNERAL DIRECTOR <b>Charles E. Haier</b>		ADDRESS <b>230 Balto Ave. Cumberland</b>		25a. REC'D BY REGISTRAR <b>JUL 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form H-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and return within 72 hours after death.

VR A15ME (3)  
10M REV. 1-66

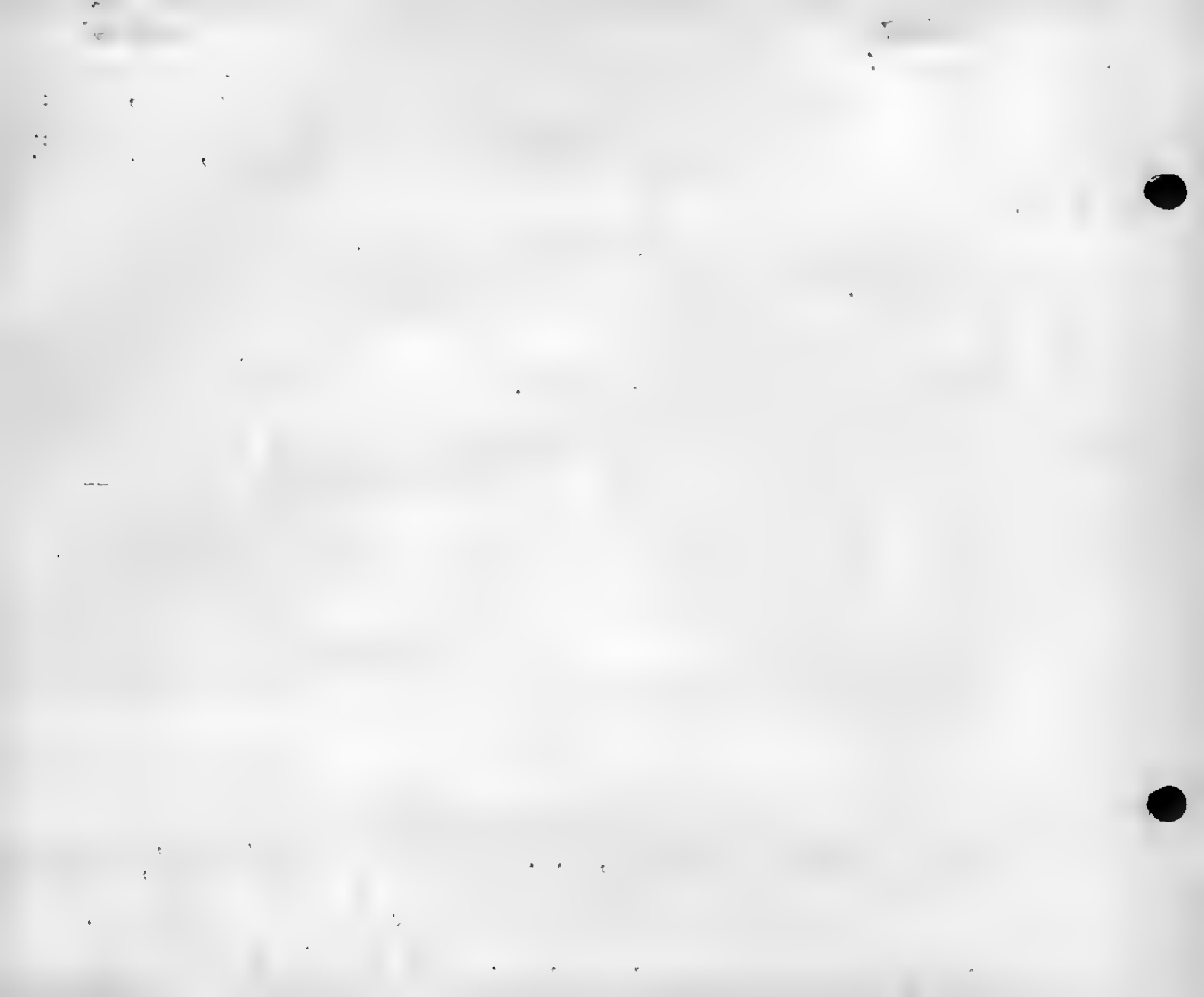
267

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09275

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			Month	Day	Year	2b HOUR
Walter			John	Drumm	2c DATE PRONOUNCED DEAD			Month	Day	Year	2d HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD			Month	Day	Year	2d HOUR
Male	White	March 1, 1896	72 YRS	MONTHS	DAYS	JULY 8, 1968			Month	Day	Year	3:00 P.M.
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH								
Maryland	USA			Allegany			Md.					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Cumberland			1805 Bedford Street			Retired Machinist			B & O R R			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d STREET AND NUMBER			
Md.			Allegany			Cumberland			1805 Bedford Street			
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			
John			Pearl Pricilla Knippenberg			NO			05-09-0365			
17 INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Mrs. Pearl Drumm			1805 Bedford Street			CORONARY OCCLUSION			SUDDEN			
Cumberland, Maryland 21502			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			CORONARY SCLEROSIS			---			
PART 1. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF						
109			DUE TO, OR AS A CONSEQUENCE OF			CORONARY SCLEROSIS						
DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			19									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town			
									County			
									State			
22a I certify that I took charge of the remains described above, held on death resulted from.			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion			Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			JULY 8, 1968			
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
						CUMBERLAND, MARYLAND						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			July 11, 1968			ST Peter & St Paul Cem.			Cumberland Allegany Md.			
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
H. Lee Silcox			404 Decatur St., Cumb., Md.			JUL 11 1968			Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First <b>ANNA</b>	Middle <b>RUTH</b>	Last <b>ENTLER</b>	2a. DATE OF DEATH Month <b>6</b> , Day <b>1968</b> , Year		2b. HOUR <b>M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MAY 14, 1898</b>		6. AGE (In years last birthday) <b>70</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.			
10. CITY OR TOWN OF DEATH <b>FROSTBURG</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MINERS HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED SEAMSTRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FACTORY</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>FROSTBURG</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>26 McCULLOH STREET</b>	
14. FATHER'S NAME First <b>HENRY</b> Middle <b>KASECAMP</b> Last <b>RUTH</b>			15. MOTHER'S MAIDEN NAME First <b>RUTH</b> Middle <b>TWIGG</b> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <b>216-18-1364</b>		17. INFORMANT Address <b>MRS. BETTY SWAUGER, FROSTBURG, MD. 21532</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cancer of the Lungs</u> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION <input checked="" type="checkbox"/>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <input checked="" type="checkbox"/>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) <input checked="" type="checkbox"/>			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL</u> , 1966, to <u>7-6</u> , 1968, that (I) (we) lost saw the deceased alive on <u>7-6</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Martin Rothstein</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>7-8-68</u>				
22d. PHYSICIAN'S NAME (Type) <b>MARTIN ROTHSTEIN, M. D.</b>					22e. ADDRESS <b>48 BROADWAY, FROSTBURG, MD. 21532</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JULY 9, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ECKHART CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>ECKHART, MD.</b>			
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, FROSTBURG, MD. 21532</b>					25a. REC'D BY REGISTRAR <b>JUL 11 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		





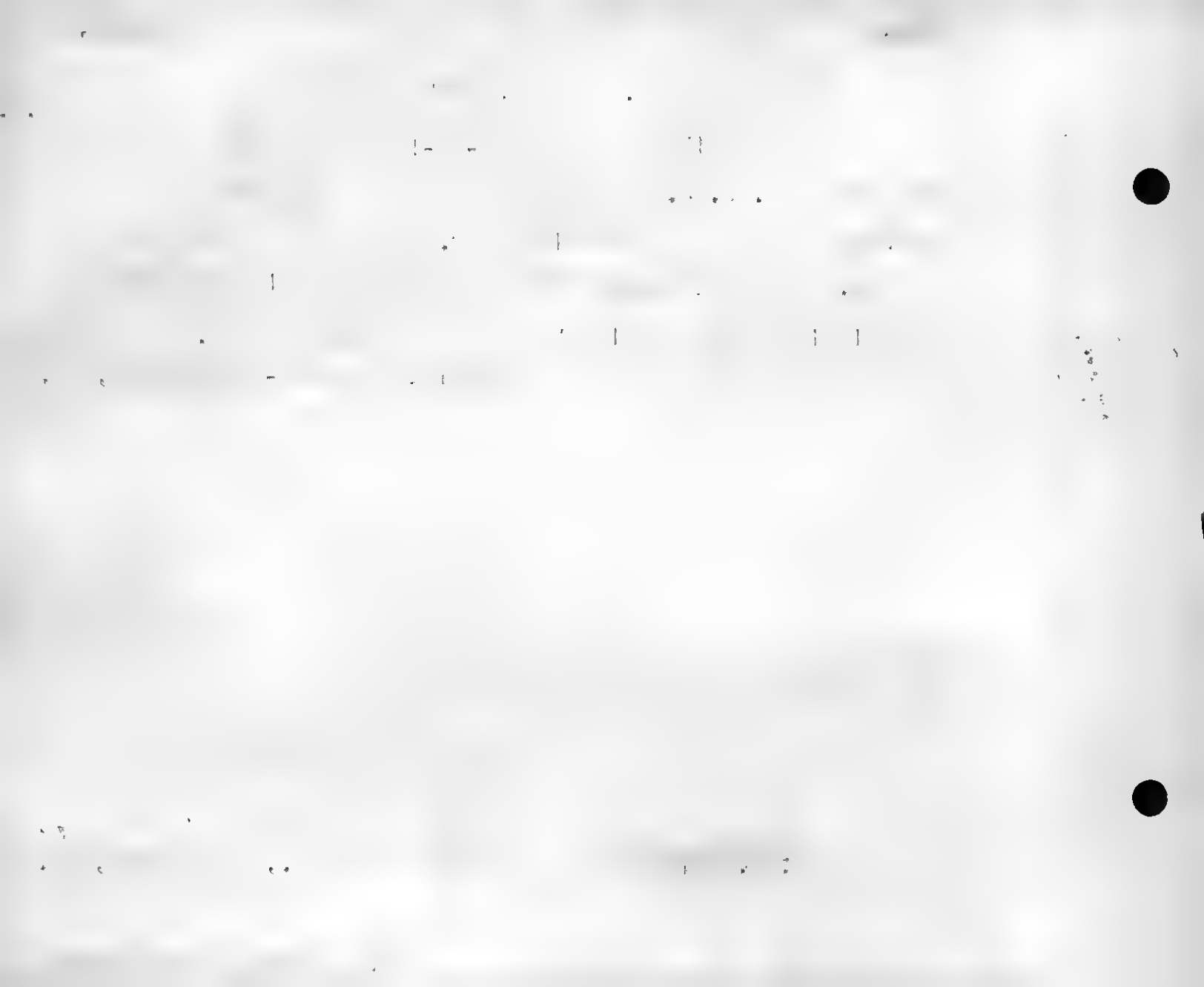
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)		First <b>MARY</b>		Middle <b>V.</b>		Last <b>FAIRALL</b>		2a. DATE OF DEATH Month <b>7</b> Day <b>27</b> Year <b>68</b>		2b. HOUR <b>10:00</b>
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>2-27-1908</b>		6. AGE (In years last birthday) <b>60</b> YRS		7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>		Md		
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSP.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Mkt.</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>MD.</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>221 SOUTH STREET</b>		
14 FATHER'S NAME First <b>WILLIAM</b>		Middle <b>FAIRALL</b>		Last <b>FAIRALL</b>		15. MOTHER'S MA DEN NAME First <b>ETHEL</b>		Middle <b>L.</b>		Last <b>NIXON</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>		16b. SOCIAL SECURITY NO.		17 INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Stroke</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Stroke</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>July 27, 1968</u> to <u>July 27, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>DR. BLANE SCHINDLER</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>July 27, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>DR. BLANE SCHINDLER</b>						22e. ADDRESS <b>88 GREENE ST., CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>July 30, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>				
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>JUL 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose in separate papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1500  
304 REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="text-align: center;"> <div>09278</div> <div>CERTIFICATE OF DEATH</div> <div>09278</div> </div>										
1. DECEASED NAME (Type or print)		First ANNA		Middle MARY		Last GERO		2a. DATE OF DEATH Month Day Year JULY 14 1968		2b. HOUR 3:55 A
3 SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH OCTOBER 15, 1915		6. AGE (In years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M.N.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.				
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housekeeper - At home		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 251 N. MECHANIC ST.		
14. FATHER'S NAME First Middle Last MELVIN C. LOWERY		15. MOTHER'S MAIDEN NAME First Middle Last BESSIE FAULKNER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 217-10-5788		17 INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND				
18 CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u>										5 months
1621 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
1621										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (the hospital) attended the deceased from <u>June</u> , 19 <u>68</u> , to <u>July 14</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>July 13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>G.O. Himmelwright</i>		DEGREE DR. G.O. HIMMELWRIGHT		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7-15-68				
22d. PHYSICIAN'S NAME (Type) DR. G.O. HIMMELWRIGHT		22e. ADDRESS VIRGINIA AVENUE, CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/17/68		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland				
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland Maryland 21502				25a. REC'D BY REGISTRAR DATE JUL 17 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
10M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09279

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Joseph Andrew Grimm						Month Day Year			JULY 4 1968		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	F UNDER 1 YEAR		F UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	June 14, 1928	40 YRS	MONTHS	DAYS	HOURS	MIN	JULY 4, 1968			18:47 PM
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Frostburg, Md.			USA						Allegany Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			MEMORIAL HOSPITAL-DOA			Farmanster-Clerk			Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER		
W. VA.			MINERAL RIDGELEY			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			10 Third Ave., Ridgeley		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
James J. Grimm			Anna A. Miller								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No						Ronald T. Grimm, Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CORONARY OCCLUSION, LEFT											SUDDEN
DUE TO, OR AS A CONSEQUENCE OF											
(b) CORONARY THROMBOSIS											SUDDEN
DUE TO, OR AS A CONSEQUENCE OF											
(c) CORONARY SCLEROSIS											---
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY?											
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			19 P.M.								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			JULY 4, 1968					
BENEDICT SKITARELIC, M.D.			ADDRESS (Street, city, town or county)			CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			July 8, 1968			Sunset Memorial Park			Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
James F. Scarpelli, Cumberland, Md.						JUL - 8 1968			Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR 175 (M)  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09280  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) First <b>WILBUR</b> Middle <b>E</b> Last <b>HAINES</b>			2a. DATE OF DEATH Month <b>7</b> Day <b>14</b> Year <b>68</b>		2b. HOUR <b>2:45</b> P.M.
3 SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5 DATE OF BIRTH <b>8-17-12</b>	6 AGE (In years last birthday) <b>55</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>
7a BIRTHPLACE (State or foreign country) <b>W. VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>ALLEGANY</b>		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital during most of working life, even if retired) <b>MEMORIAL HOSPITAL</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Salvage</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Haines Auto Wreckers</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>W.VA.</b>	13b. COUNTY <b>Mineral</b>	13c CITY OR TOWN <b>RIDGELEY</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <b>XXXXXX</b>	<b>BOX 462</b>
14. FATHER'S NAME First <b>WILLIAM</b> Middle <b>HAINES</b> Last <b>HAINES</b>	15. MOTHER'S MAIDEN NAME First <b>RHODA</b> Middle <b>PARRILL</b> Last <b>PARRILL</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>NO</b> (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO		17 INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissecting Thoracic Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4-11-68</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 10 1968</b> , to <b>July 14 1968</b> , that (I) (we) last saw the deceased alive on <b>July 14 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE 		DEGREE <b>MD</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <b>DR. G. O. HIMMELWRIGHT</b>		22c. DATE SIGNED <b>7-15-68</b>			
22e. ADDRESS <b>CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/18/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>		
24. FUNERAL DIRECTOR <b>Philip B. Wendt</b>		ADDRESS <b>121 Memorial Ave., Cumb. Md.</b>	25a. REC'D BY REGISTRAR <b>JUL 18 1968</b>	25b. REGISTRAR'S SIGNATURE 	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, 3 and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										69281			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH			2b. HOUR	
Maude Mae Hansell									XX Month Day Year MATED <input type="checkbox"/> July 24 19 68			4:35 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PROMOUNCED DEAD	
Female		White		Oct. 5, 1883		84 YRS		MONTHS		DAYS		2d. HOUR	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
W. Va.		USA		WIDOWED <input checked="" type="checkbox"/>		D.VORCED <input type="checkbox"/>		Allegany		Housewife		Own Home	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland				Memorial Hospital				Housewife				Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution, give address)				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?	
Md.				Allegany				Cumberland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER				13f. STREET AND NUMBER				13g. STREET AND NUMBER				13h. STREET AND NUMBER	
613 Oldtown Road				613 Oldtown Road				613 Oldtown Road				613 Oldtown Road	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. SOCIAL SECURITY NO				17. INFORMANT	
Albert Ensley				Rachael Shank								Mr. Howard V. Hansell, Cumberland, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT				ADDRESS	
no												Mr. Howard V. Hansell, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:												Hours	
IMMEDIATE CAUSE (a) Acute Pulmonary Edema													
DUE TO, OR AS A CONSEQUENCE OF													
4129 (b) Arteriosclerotic Cardiovascular Disease												-----	
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Diabetes mellitus, Fracture of Left Femur neck.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								XXXX NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
				9 HOUR A.M. P.M. May 13 19 68				Fell in bedroom of home					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
				Home				613 Oldtown Road, Cumberland, Allegany, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				July 24, 1968					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
Burial				July 26, 1968				Hillcrest Burial Park					
								Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
James F. Scarpelli, Cumberland, Md.				DATE JUL 29 1968				J. Charles Judge					



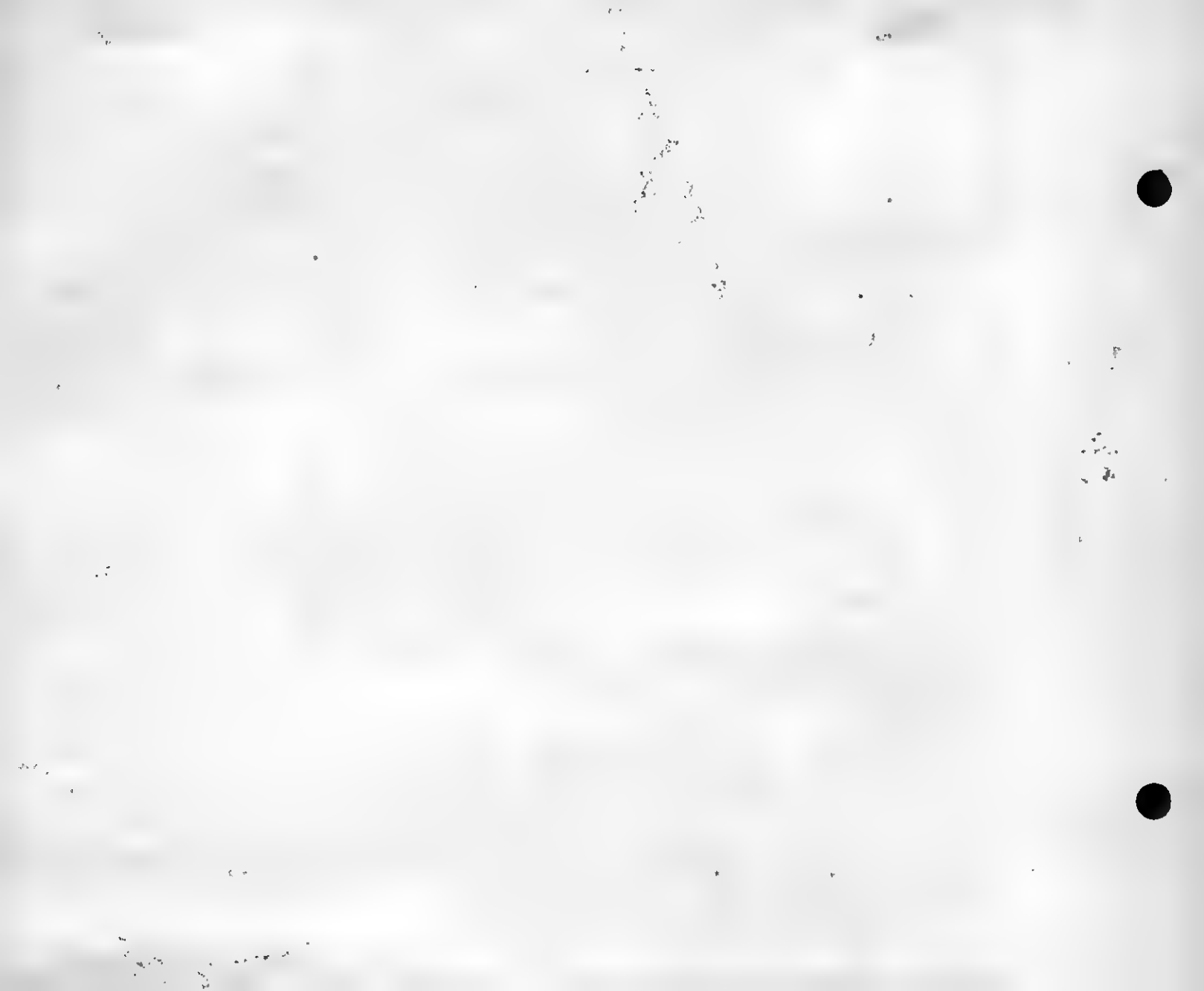
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09282  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>EMMA</b>			First <b>J</b>			Middle <b>HARE</b>			Last <b>HARE</b>			2a. DATE OF DEATH Month <b>JULY</b> Day <b>30</b> Year <b>1968</b>			2b. HOUR <b>1:10</b>					
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>5-30-1892</b>			6. AGE (In years lost birthday) <b>78</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS. HOURS MIN					
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b>											
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HWFE.</b>			12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>ALLEGANY</b>			13c. CITY OR TOWN <b>CUMBERLAND</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>823 LAFAYETTE AVENUE</b>								
14. FATHER'S NAME <b>THEOPHILUS</b>			First <b>BARGER</b>			Middle <b>MARY</b>			Last <b>HARRISON</b>			15. MOTHER'S MAIDEN NAME <b>MARY HARRISON</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocarditis &amp; Decompensation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i> <i>5 yrs</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <i>March 10</i> , 19 <i>68</i> , to <i>July 30</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>July 29</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																				
22b. SIGNATURE <i>Clay E. Durrett</i>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <b>7/30/68</b>											
22d. PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>			22e. ADDRESS <b>236 VIRGINIA AVE., CUMBERLAND, MD.</b>																	
23a. BURIAL (CREMATION, REMOVAL (Specify)) <b>Burial</b>			23b. DATE <b>Aug. 1, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>			23d. LOCATION (City or Town) (County) (State) <b>Points, W. Va.</b>											
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>			ADDRESS			25a. REC'D BY REGISTRAR <b>AUG 5 1968</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09283

1. DECEASED-NAME (Type or print)		First ALICE	Middle GERTRUDE	Last HAUS	2a. DATE OF DEATH JULY Month 10 <sup>day</sup> 1968		2b. HOUR 11 A M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH NOV 14, 1890		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MT. SAVAGE MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY CO. Md.			
10. CITY OR TOWN OF DEATH LONOCONING MARYLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KYLE NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Store Keeper		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Mt. Savage		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Main Street	
14. FATHER'S NAME First Samuel Middle C. Last Haus		15. MOTHER'S M.A.DEN NAME First Jenny Middle Last Jenkins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) NO		16b. SOCIAL SECURITY NO. 217-24-4063		17. INFORMANT Main Street Gilbert S. Haus Mt. Savage, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease years DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis years Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1965, to 6-10, 1968, that (I) (we) lost saw the deceased alive on 6-8-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L.R. Miles, Jr. M.D.					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7-11-68		
22d. PHYSICIAN'S NAME (Type) L.R. MILES, JR. M.D.					22e. ADDRESS LONACONING MD. 21539				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland			
24. FUNERAL DIRECTOR H. Lee Silcox 404 Decatur St., Cumb., Md.				ADDRESS		25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

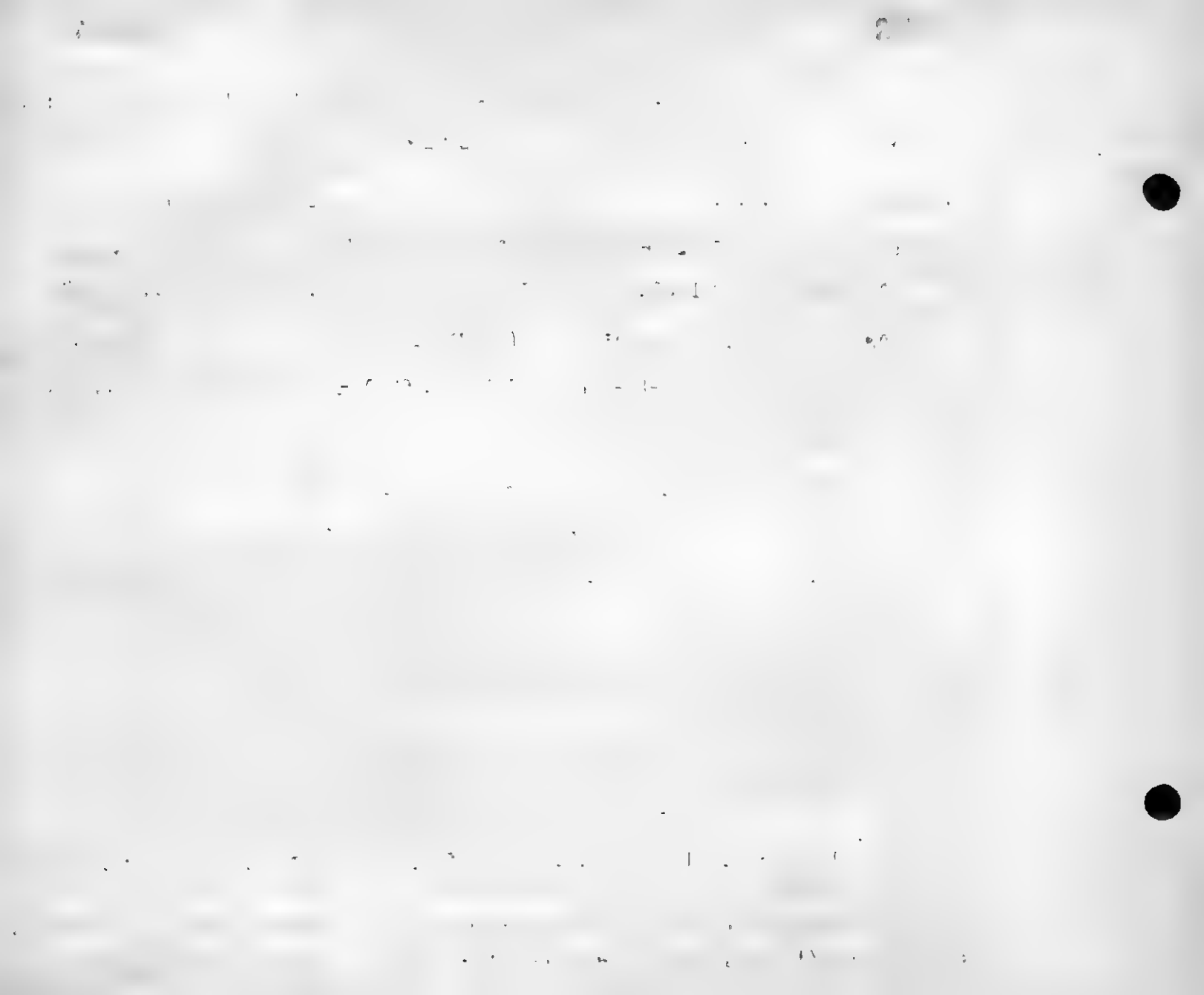


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151 (1)  
30M REV 4/76

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>EVA</b>			First <b>P.</b> Middle <b>HUGHES</b> Last			2a. DATE OF DEATH <b>07</b> Month <b>10</b> Day <b>68</b> Year		2b. HOUR <b>4:55</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>04-14-99</b>		6. AGE (In years last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY COUNTY</b> Md.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIM IT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>N. MECHANIC ST., KENNEDY</b>	
14. FATHER'S NAME First <b>FRANK</b> Middle <b>D.</b> Last <b>HUGHES</b>			15. MOTHER'S MAIDEN NAME First <b>(COWGILL)</b> Middle <b>IDA</b> Last <b>HUGHES</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>217-10-6518</b>		17. INFORMANT Address <b>HOSPITAL RECORDS-900 SETON DR., CUMB., MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4127 Congestive Heart failure.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>(b) Coronary - sclerosis Cardio-vascular dis.</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c) Generalized Atrial - sclerosis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1. Cerebral Thrombosis - Left Hemiparesis.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Clarence J. Vincent M.D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <b>CLARENCE J. VINCENT, M.D.</b>				22e. ADDRESS <b>126 N. SMALLWOOD ST., CUMB., MD. 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 13 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md.</b>			
24. FUNERAL DIRECTOR <b>KIGHT'S FUNERAL HOME, 309 DECATUR ST., CUMB.</b>				25a. REC'D BY REGISTRAR <b>JUL 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

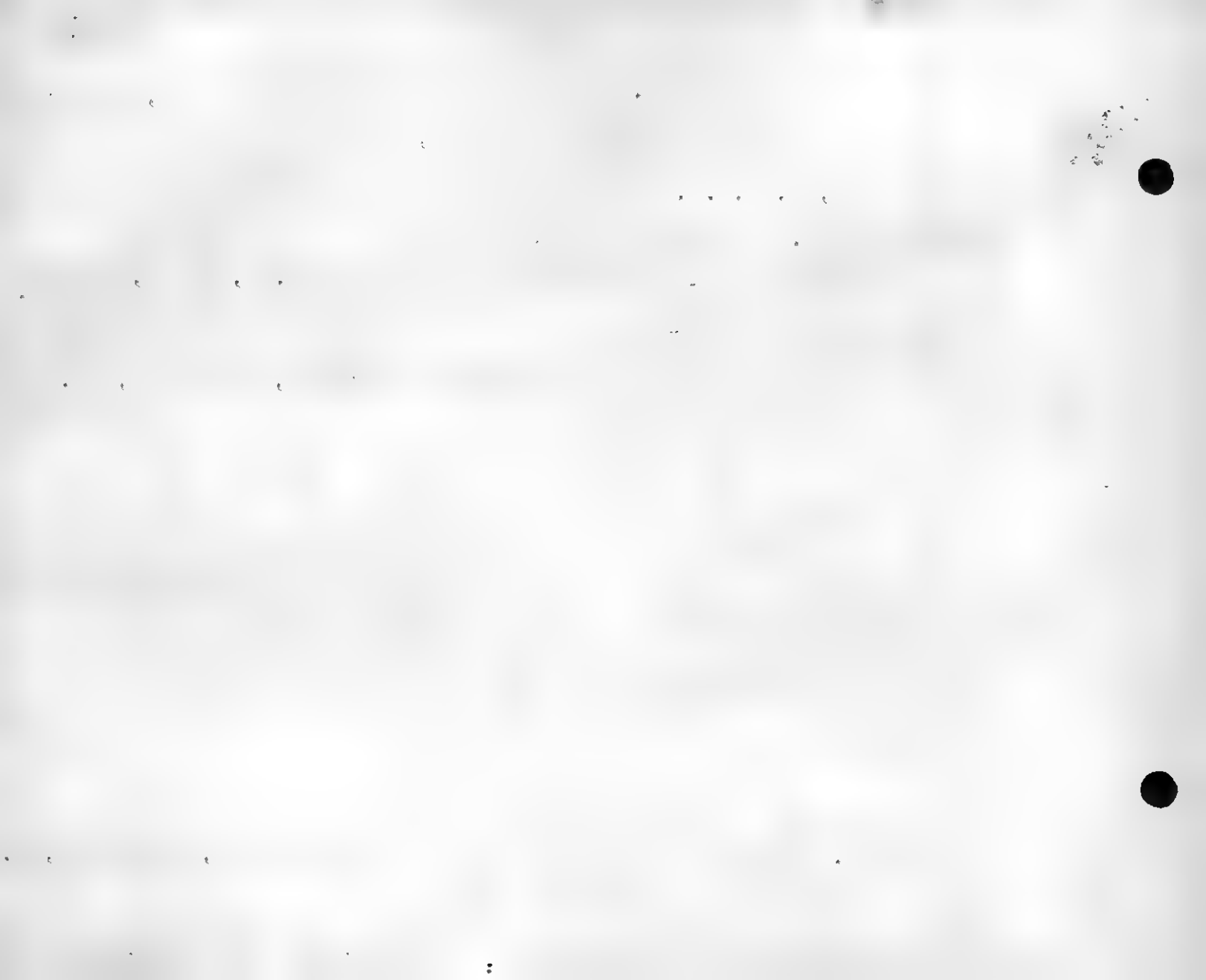




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First <b>JOHN</b>		Middle <b>S.</b>		Last <b>HUMMEL</b>		2a DATE OF DEATH Month <b>JULY</b> Day <b>22</b> Year <b>1968</b>		2b HOUR <b>1:05</b> AM
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>			5 DATE OF BIRTH <b>MAY 5, 1908</b>			6 AGE (In years last birthday) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>GRANTSVILLE, MD.</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY</b>			
10 CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Textile</b>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b> 13b. COUNTY <b>ALLEGANY</b>			13c CITY OR TOWN <b>CUMBERLAND</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>RT. #1, BOX 17, GRAMLICH RD.</b>			
14 FATHER'S NAME First <b>HARRY</b> Middle <b>HUMMEL</b> Last <b>HUMMEL</b>			15. MOTHER'S MAIDEN NAME First <b>DELLA</b> Middle <b>POLEMAN</b> Last <b>POLEMAN</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW 2</b>			16b SOCIAL SECURITY NO. <b>217-10-5419</b>			17 INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Obstruction of abdominal aorta</b> DUE TO, OR AS A CONSEQUENCE OF <b>acute Thrombosis or embolus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Thrombosis or embolus</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 mos.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY) OFFICE BUILDING, ETC			21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>6 June 1968</b> , to <b>22 July 1968</b> , that (I) (we) last saw the deceased alive on <b>22 July 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <b>Edward Stasko M.D.</b>			22c. PHYSICIAN'S NAME (Type) <b>DR. HADIDIAN</b>			22d ADDRESS <b>203 GREENE STREET, CUMBERLAND, MD.</b>		22e. DATE SIGNED <b>7-22-68</b>			
23a B. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>Jul. 24, 1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Garden Rest Lawn Memorial</b>			23d LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md</b>			
24. FUNERAL DIRECTOR <b>William G. Kight</b> <b>Cumberland, Md.</b>						25a. REC'D BY REGISTRAR <b>JUL 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHO Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

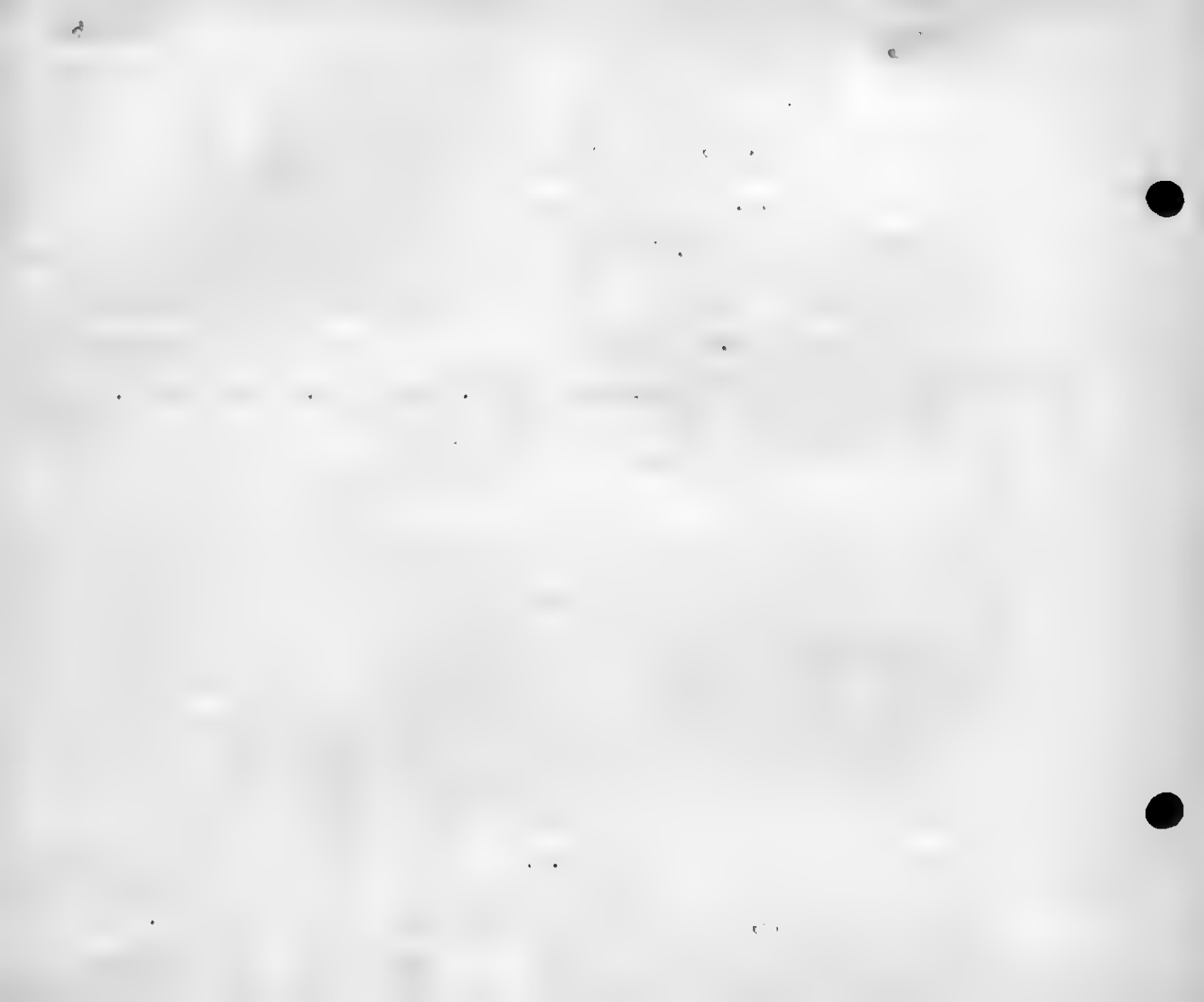
VR A15ME 15  
10M REV 1-68

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69286

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b HOUR				
JOHN			LEE			JOHNSON			JULY 9, 1968			3:00				
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR					
MALE	WHITE	OCT. 12, 1947	20 YRS	MONTHS		DAYS		JULY 9, 1968			4:00					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md				
MARYLAND			U.S.A.						ALLEGANY							
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY							
CUMBERLAND			RT. 40			LABORER - CONSTRUCTION COMPANY										
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER				
MARYLAND			ALLEGANY			FROSTBURG			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			30 HILL STREET				
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME													
JOHN H. JOHNSON			MAE ROSENBERGER													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS							
NO			214-52-1263			JOHN L. JOHNSON,			FROSTBURG, MD. 21532							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)													SHOCK		1-2 Hour	
DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													EXANGUINATION		1-2 Hours	
DUE TO, OR AS A CONSEQUENCE OF																
(c)													Crushed right forearm		1-2 Hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
MEDICAL CERTIFICATE ON																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					21b TIME OF INJURY Month, Day, Year					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
					2:00 PM 7-9-68 19					Driver of auto involved in accident						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e PLACE OF INJURY (At home, farm, street, factory, office, bus, etc.)					21f LOCATION Street or RFD No City or Town County State						
					RT. 40 16 miles east of					Cumberland, Allegany, Maryland						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE					BENEDICT SKIPARELIC, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)										22b DATE SIGNED						
										JULY 9, 1968						
										ADDRESS (Street, city, town, or county)						
										CUMBERLAND, MARYLAND						
23a BURIAL CREMATION, REMOVAL (Specify)					23b DATE					23c NAME OF CEMETERY OR CREMATORY						
BURIAL					JULY 12, 1968					GRANTSVILLE CEMETERY						
										23d. LOCATION (City or Town) (County) (State)						
										GRANTSVILLE, MD.						
24 FUNERAL DIRECTOR					ADDRESS					25a REC'D BY REGISTRAR						
JOSEPH R. DURST, FROSTBURG, MD. 21532										JUL 15 1968						
										25b REGISTRAR'S SIGNATURE						
										Charles Judge						

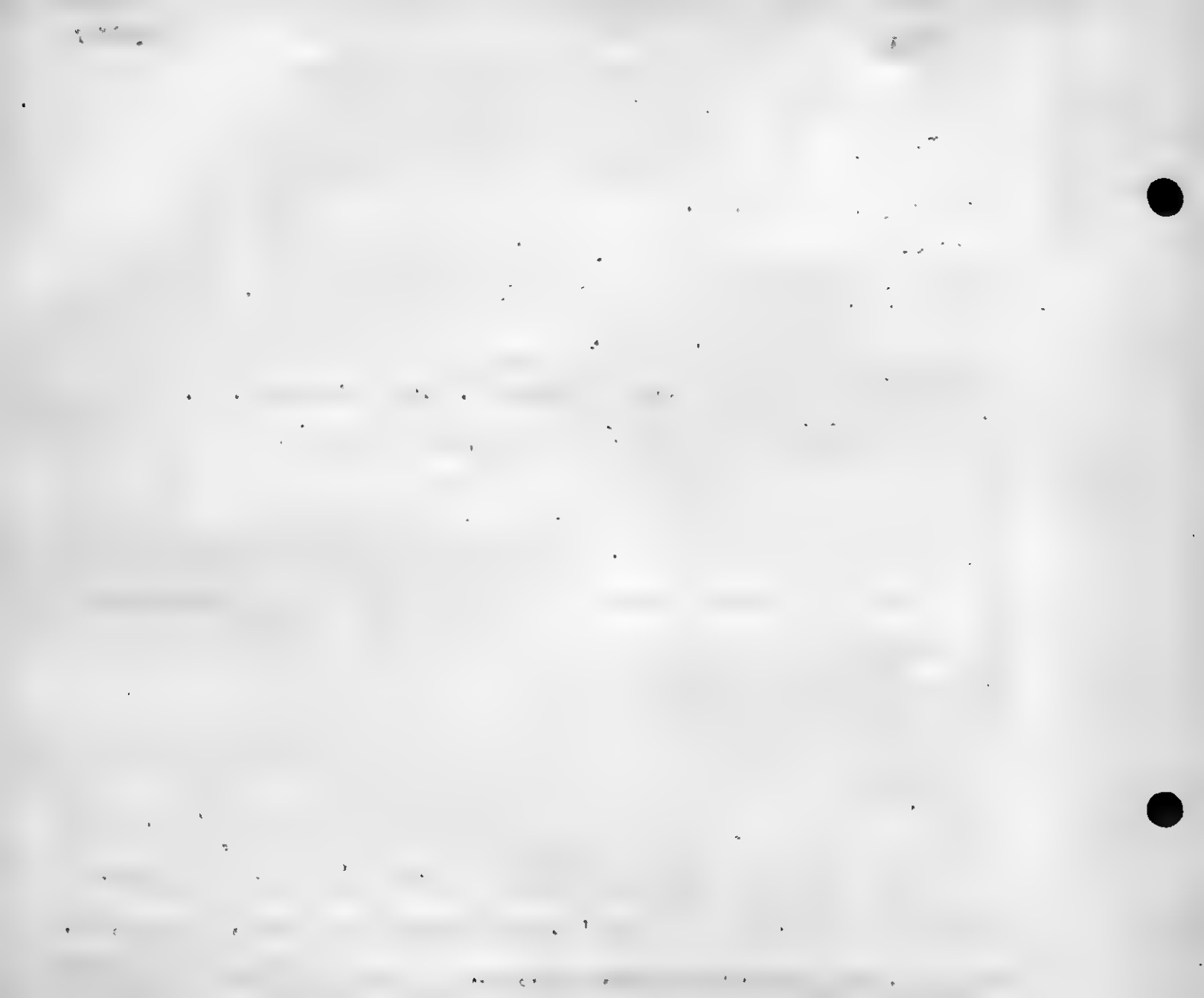


## CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <u>Childred</u>		First <u>Page</u>		Middle <u>John</u>		Last <u>Page</u>		2a DATE OF DEATH July Month Day <u>03</u> Year		2b HOUR 9 P.M.	
3 SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>2/23/87</u>		6. AGE (In years last birthday) <u>1</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Allegany</u> Md.					
10. CITY OR TOWN OF DEATH <u>Cumberland</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>St. John's Retreat</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Teacher</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Allegany</u>		13c. CITY OR TOWN <u>Cumberland</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>7217 1st Street</u>			
14 FATHER'S NAME <u>Sylvester</u>		First <u>John</u>		Middle <u>Page</u>		15 MOTHER'S MAIDEN NAME <u>Blide</u>		First		Middle	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <u>No</u>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>None</u>		17 INFORMANT <u>Lois A. Bolka Ridgeley, W. Va.</u>		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 2 days</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.</u> <u>many years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>CHC A24-D with Hypertension</u> <u>many years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) .											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>7/10/68</u> , 19 <u>68</u> , to <u>7/10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John A. Topper</u>		DEGREE <u>M.D.</u>		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>July 8 - 1968</u>	
22d. PHYSICIAN'S NAME (Type) <u>John A. Topper</u>		22e. ADDRESS <u>Memorial Hospital, Cumberland, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/10/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany, Md.</u>					
24. FUNERAL DIRECTOR <u>Philip B. Wendt</u>		ADDRESS <u>121 Memorial Ave. Cumb., Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 11 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

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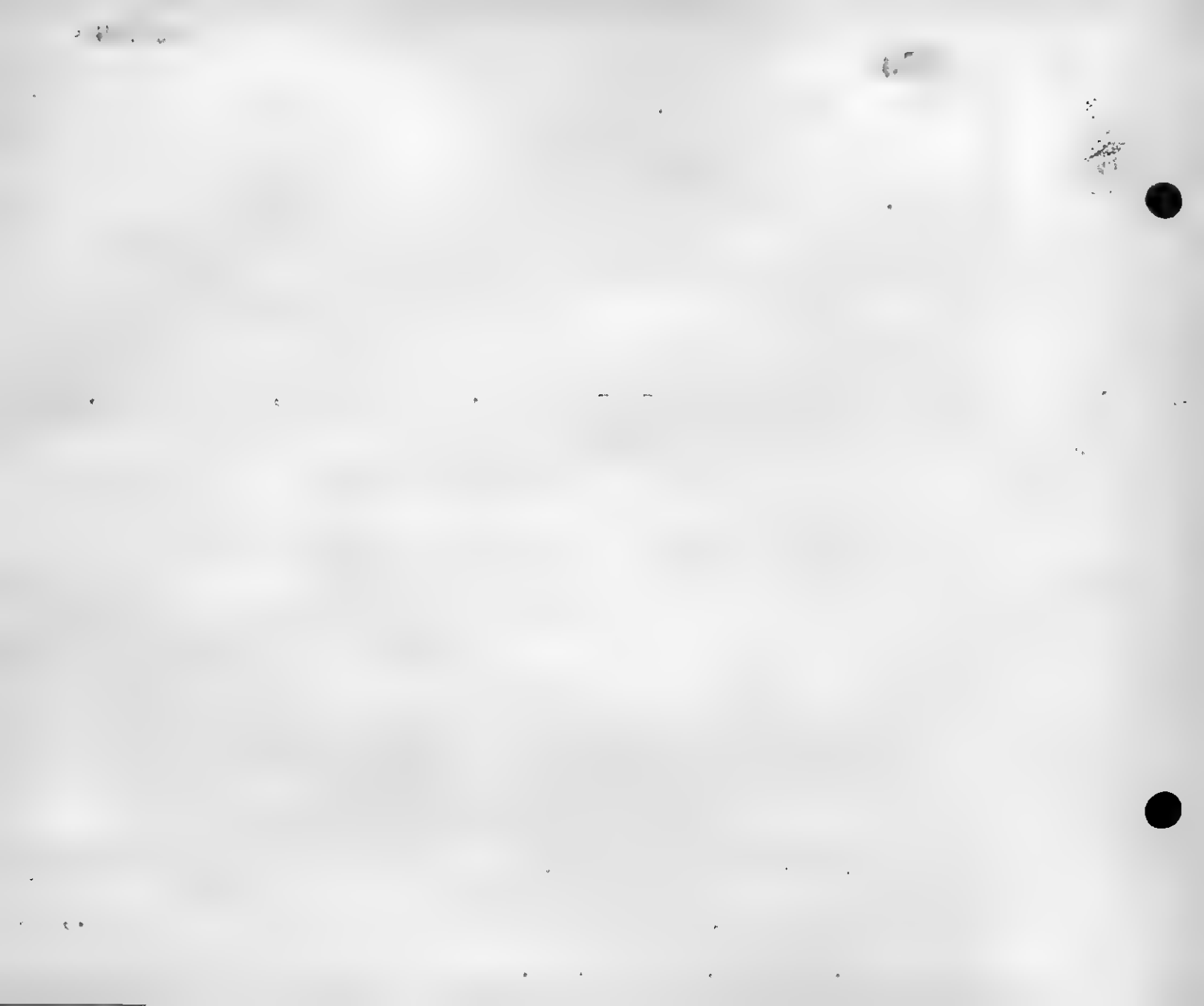


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
James W. Kerns						7 18 19 68					5:16
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (n years last birthday)	7 UNDER 24 HRS MONTHS	8 YEARS	9 IF UNDER 24 HRS HOURS	10 MIN	2c DATE PRONOUNCED DEAD		Month	Day
Male	White	May 24, 1904	64 YRS.					19			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			1d HOUR		
W. Va.		USA				Allegany			M		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			M		
Cumberland		Memorial Hospital Barber				Gonsorial					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Penna		Bedford		Hyndman		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Jacob Kerns						Evaline Moreland					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		214-07-0118		Mrs. Marian Kerns, Hyndman, Pa.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS LEFT											
4107 DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS										SUDDEN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. P.M. 19									
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)										July 18, 1968	
										ADDRESS (Street, city, town, or county) Cumberland, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		July 20, 1968		Hyndman Cemetery		Hyndman, Bedford Co., Pa.					
24. FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Harvey H. Zeigler, Hyndman, Pa.						DATE JUL 24 1968		J Charles Judge			

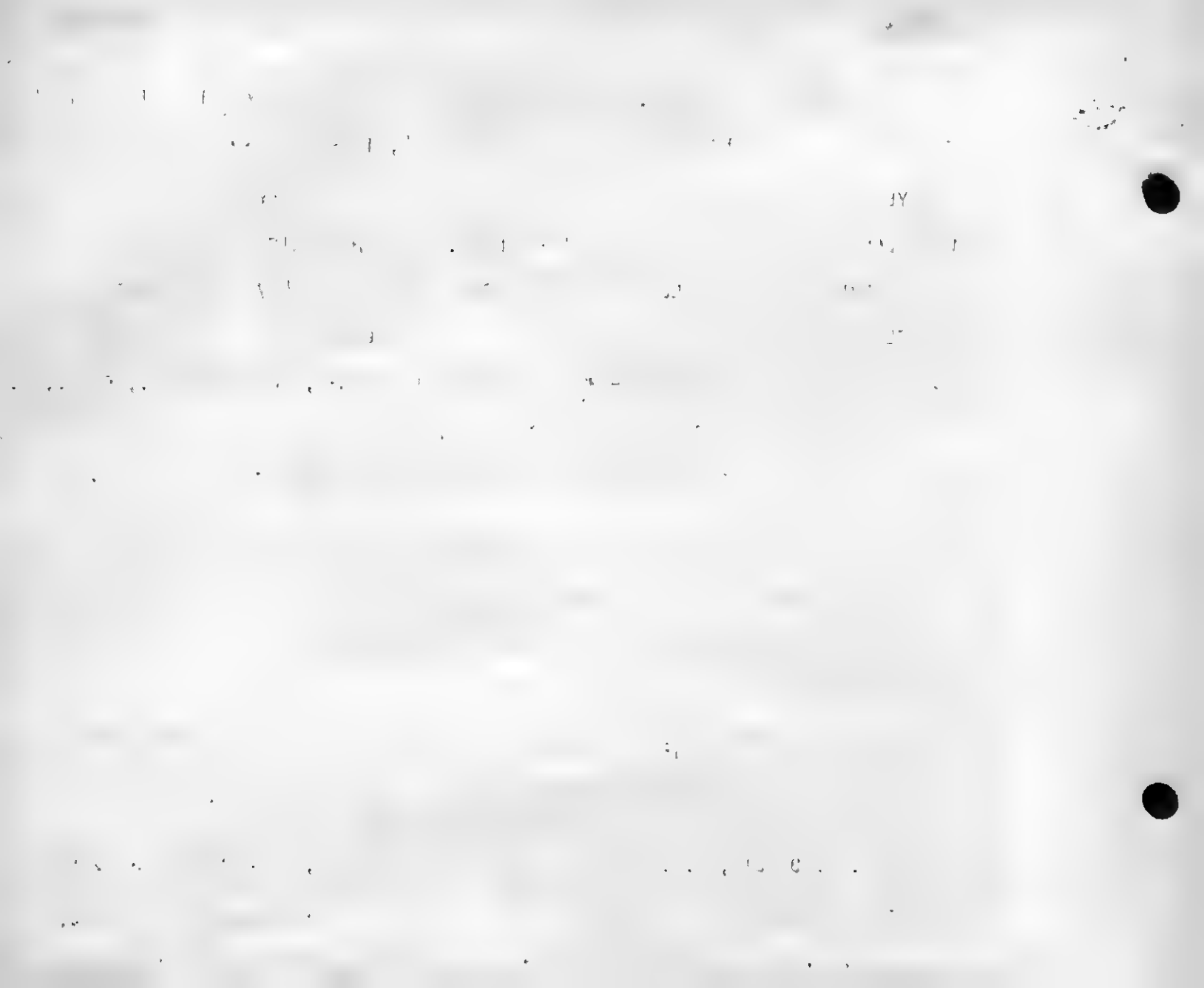




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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last ANNIE M. KLINE					2a. DATE OF DEATH JULY 19 1968			2b. HOUR 11:15 P	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 4, 1885		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of preceding year, or if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN WESTERNPORT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 427 VINE STREET	
14. FATHER'S NAME First Middle Last ELLSWORTH CROWE			15. MOTHER'S MAIDEN NAME First Middle Last MARGARET TEASDALE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-34-2064		17. INFORMANT Address HOSPITAL RECORDED, 900 SETON DR., CUMB., MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4129 DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MOS 2 YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4 x x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7 - 15, 19 68, to 7 - 15, 19 68, that (I) (we) last saw the deceased alive on 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. W. Ballin				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) R. W. BALLIN, M.D.				22e. ADDRESS 62 GREENE ST, CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/18/68		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City or Town) (County) (State) Westernport Md.			
24. FUNERAL DIRECTOR Earl Boal				ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE JUL 22 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

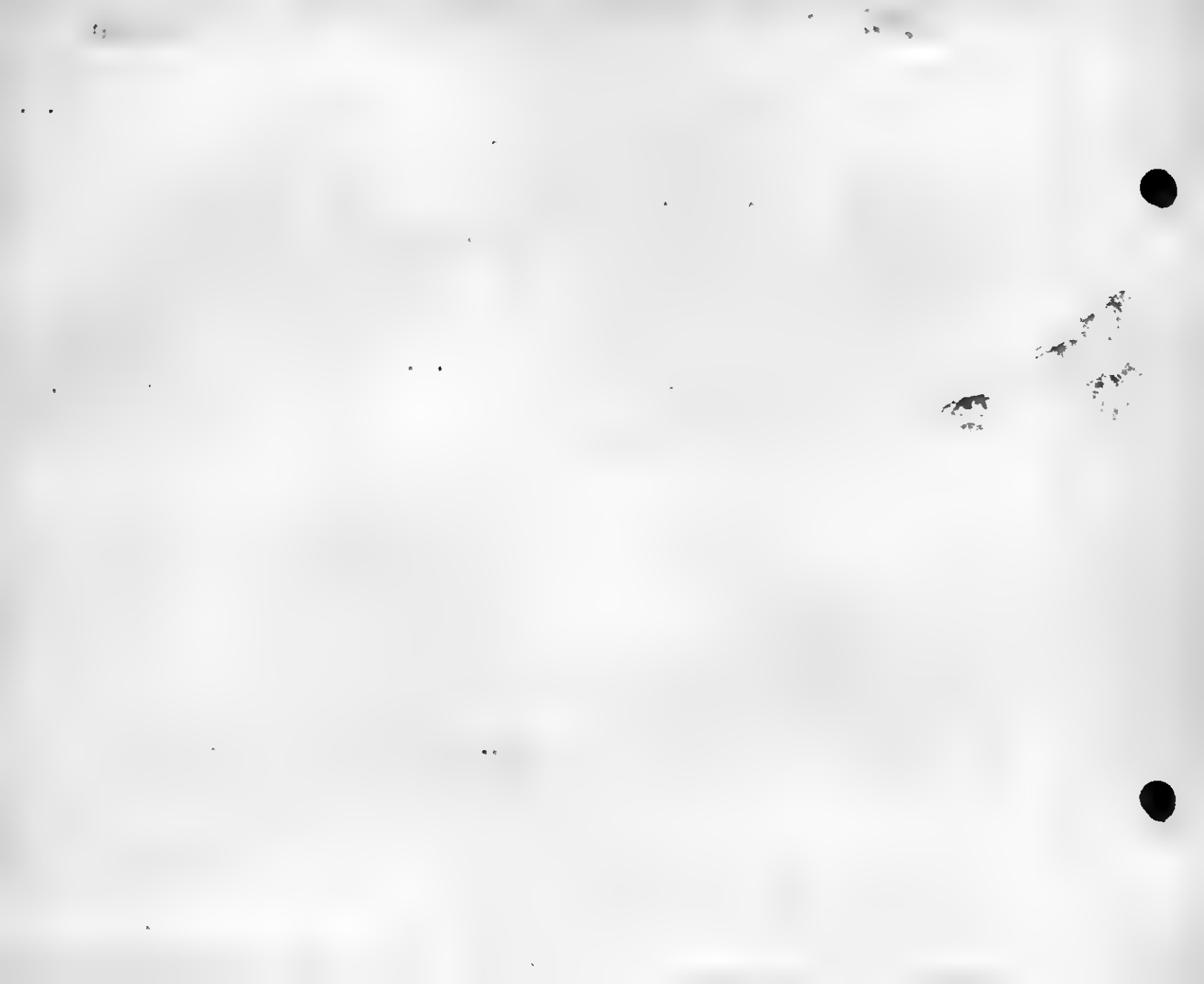


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09290  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Elizabeth Klitsch</b>		2a. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1968</b>		2b. HOUR <b>8:05 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>1/13/1883</b>	6. AGE (In years last birthday) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Allegany County</b> Md.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Allegany Co. Infirmary</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Seamstress</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Martin Store</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>509 Furnace Street</b>
14. FATHER'S NAME First <b>Gottlieb</b> Middle <b>Klitsch</b> Last <b>Klitsch</b>	15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>Wiegand</b> Last <b>Wiegand</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <b>215-05-7151A</b>	17. INFORMANT <b>P.O. Box 599, Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C. U. A.</b> <b>4067</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>you</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 6, 1961</b> to <b>July 29, 1968</b> , that (I) (we) lost saw the deceased alive on <b>July 29, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>George M. Simons</b>	DEGREE <b>M.D.</b>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>7/30/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>GEORGE M. SIMONS, M.D.</b>	22e. ADDRESS <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>8/1/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND MD.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>	25a. REC'D BY REGISTRAR <b>AUG 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

09291

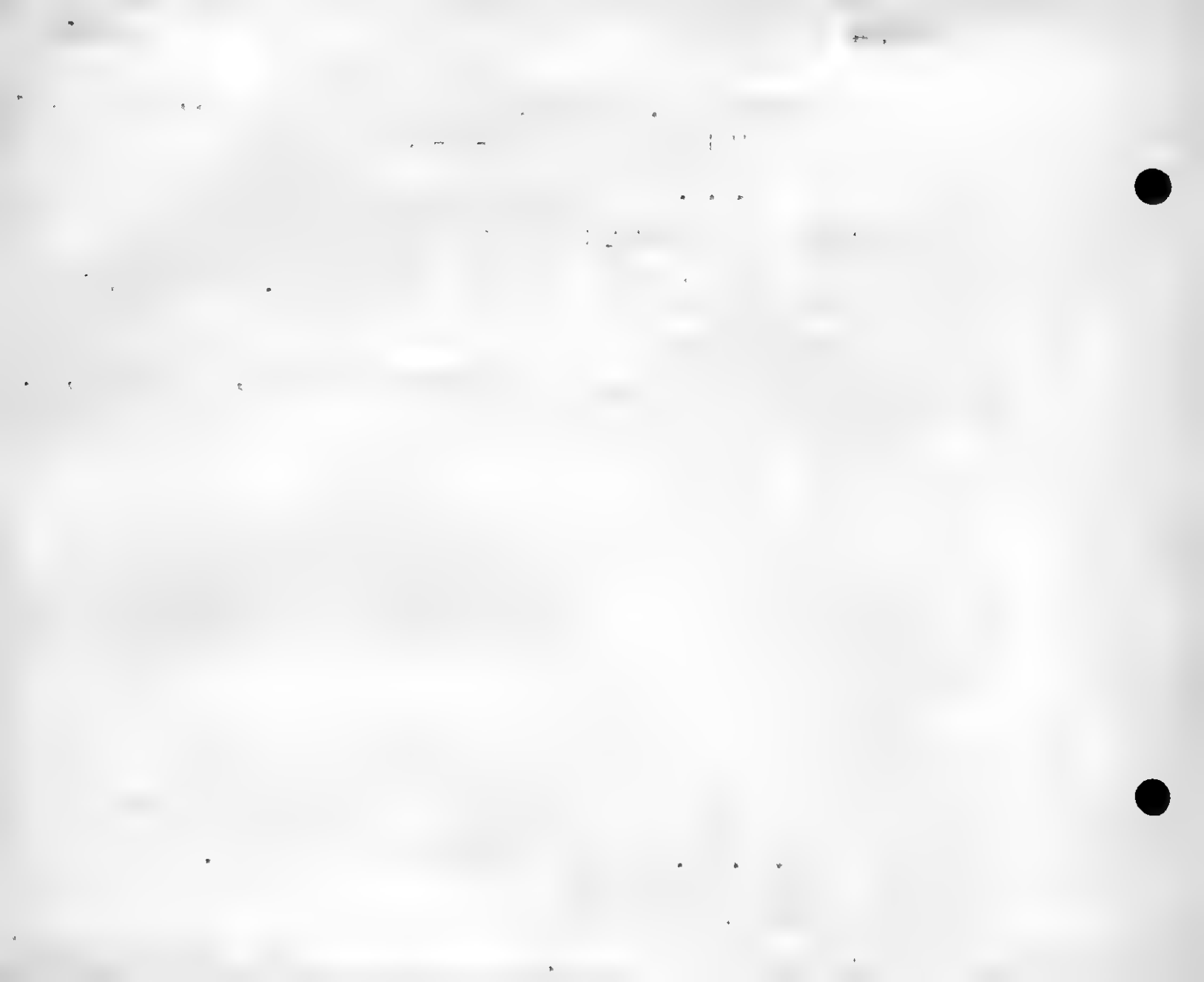
1. DECEASED NAME (Type or print) <b>GERTRUDE</b>			First Middle Last <b>B. LANCASTER</b>			2a. DATE OF DEATH <b>07</b> Month <b>11</b> Day <b>68</b> Year			2b. HOUR <b>9:40</b> PM		
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>11-15-91</b>			6. AGE (In years last birthday) <b>76</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b> Md.		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>			13c. CITY OR TOWN <b>MT. SAVAGE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <b>BOX 384</b>			14. FATHER'S NAME First Middle Last <b>CHARLES LANCASTER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>(ROONEY) CATHERINE LANCASTER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>213-10-7053</b>			17. INFORMANT Address <b>HOSPITAL RECORDS-900 SETON DR., CUMB., MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Coronary Artery Heart Disease unacutid c</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis cvo.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>10 yrs.</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>NONE</b>											
19a. DATE OF OPERATION <b>✓</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>✓</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>✓</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <b>Month</b> Day Year <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>✓</b>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home farm, street, factory, office building etc.) <b>✓</b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b>✓</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>6-28, 1968</b> to <b>7-11, 1968</b> , that (I) (we) lost the deceased alive on <b>7-11, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Martin M. Rothstein</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>7-12-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN, M.D.</b>			22e. ADDRESS <b>48 BROADWAY ST., CUMB., MD. 21502</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7/15/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Frostburg Md.</b>		
24. FUNERAL DIRECTOR <b>KIGHT FUNERAL HOME-309 DECATUR ST., CUMB.</b>			ADDRESS			25a. REC'D BY REGISTRAR <b>JUL 17 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR	
KATHRYN L. LASHLEY						JULY 6, 1968		6:40 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years, last birthday)		7 UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		2-26-01		67 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Mo.	
Pennsylvania		U.S.A.				ALLEGANY			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL		Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
MD.		ALLEGANY		CUMBERLAND		NO		RT. 1 GREENPOINT	
4 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last					
Michael Thomas				Annie Lehman Thomas					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT Address			
No				216-22-6693		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4109</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <u>6/27/68</u> , 19 <u>68</u> , to <u>7/6/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/6/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED							
		7/8/68							
22d PHYSICIAN'S NAME (Type)		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
DR. R. J. WMS.									
22e ADDRESS		22f ADDRESS							
		NEW CUMBERLAND, MD.							
23a BURIAL, CREMATION, REMOVAL, (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		July 9, 1968		Palo Alto Cemetery		Hyndman RD#1 Bedford Co Pa.			
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Harvey H. Zeigler, Hyndman, Pa.						DATE JUL 12 1968		Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

VR A15  
30M REV 1-60

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

69298

# CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>CARRIE</b>		First	Middle	Last	2a. DATE OF DEATH Month <b>07</b> Day <b>18</b> Year <b>68</b>		2b. HOUR <b>7:10</b> AM	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>12-15-22 1901</b>		6. AGE (In years) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>		IF UNDER 24 HRS HOURS MIN
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>SACRED HEART HOSPITAL</b>		2a. USUAL OCCUPATION (Kind of work done during most of working life, and training) <b>COAL CO RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>USUAL</b>		Md.
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before death) <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>WESTERNPORT</b>		13d. INSIDE CITY LHM-75? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>RT. 1,</b>
14. FATHER'S NAME <b>HOWARD</b>		First	Middle	Last	15. MOTHER'S MAIDEN NAME <b>HENRIETTA</b>		First	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>Yes</b> <input checked="" type="checkbox"/> <b>No</b> <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>219-56-9720</b>		17. INFORMANT <b>SACRED HEART HOSPITAL</b>		17b. ADDRESS <b>CUMBERLAND, MD.</b>		17c. ADDRESS <b>900 SETON DR.</b>
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> <b>1841</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF VULVA</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1160</b> <b>DIABETES MELITUS</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>7-10</b> , 19 <b>68</b> , to <b>7-18</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>7-18</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Lowry Glick</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7-19-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>BRADDOCK MEDICAL GROUP - GLICK</b>				22e. ADDRESS <b>126 N. SMALLWOOD ST., CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/20/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Star Rt. Frostburg, Garrett Md.</b>		
24. FUNERAL DIRECTOR <b>Ruth Newman</b>		ADDRESS <b>Grantsville, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09294

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year <input type="checkbox"/> JULY 12, 1968				2b. HOUR p 3:50 M	
William		Lee											
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year =		2d. HOUR p 3:50 M	
M	White	1/29/1919		49 YRS.						July 12, 1968			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maryland		U.S.A.				Allegany							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. LSUA. OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		Sacred Heart Hospital-DOA		Laborer		Construction							
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Md		Allegany		Nikep									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
William Lee								Jessie Mae Matthews					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		ADDRESS							
				Mrs. Edna Lee		Nikep, Md.							
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))		PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		"Wife" CORONARY OCCLUSION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES							
4100		DUE TO, OR AS A CONSEQUENCE OF		CORONARY SCLEROSIS WITH THROMBOSIS									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201		(b)		DUE TO, OR AS A CONSEQUENCE OF									
		(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		CARDIAC HYPERTROPHY: HYPERTENSIVE CARDIOVASCULAR DISEASE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED JULY 12, 1968					
ACTUAL SIGNATURE Benedict Skitarelic		M.D.		ADDRESS (Street, city, town, or county) GUMBERLAND, MARYLAND									
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/15/68		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Moscow A. Md							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 15 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge							
George Eichhorn		Lonaconing, Md.											

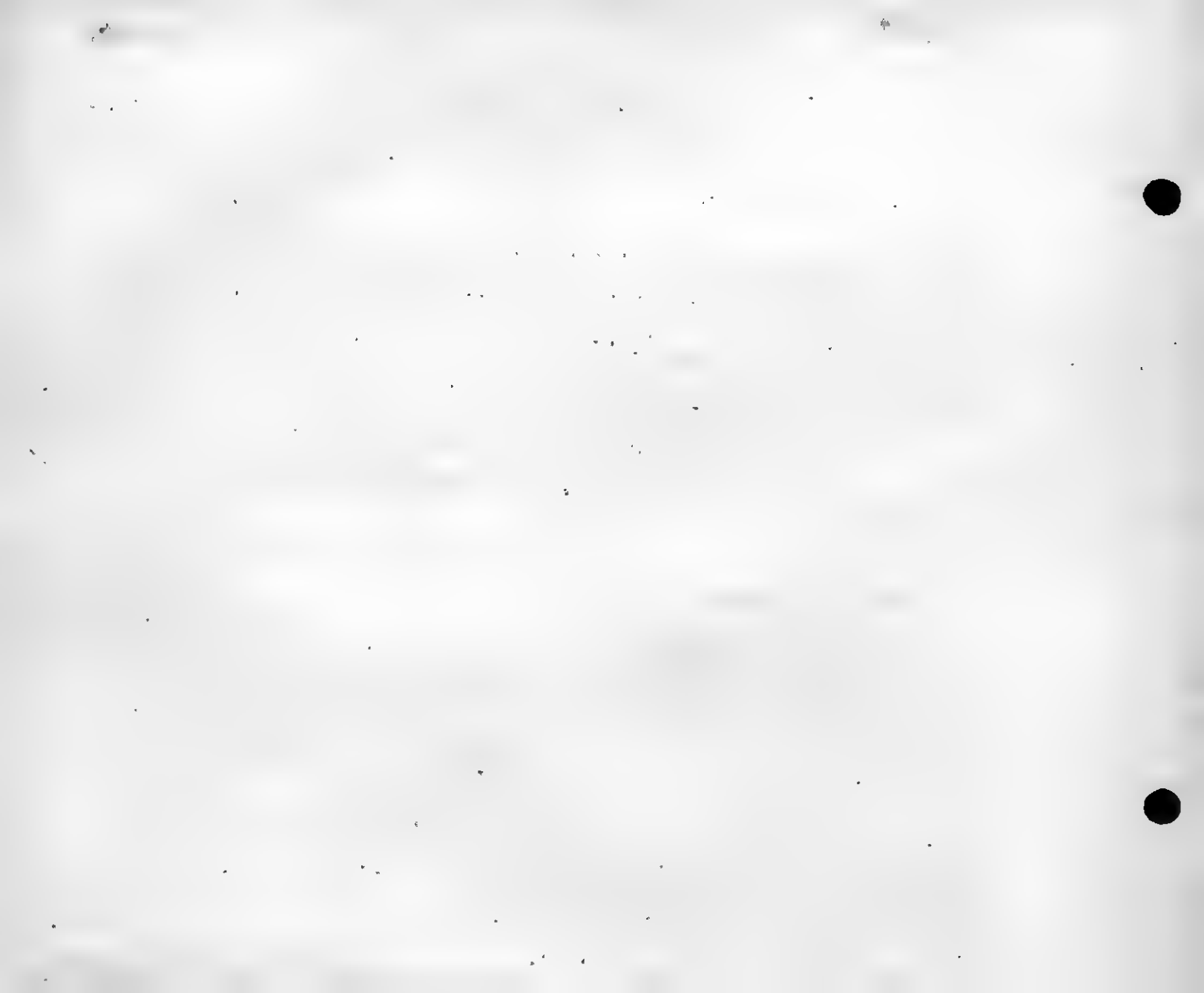


## CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR		
Raymond H. Leighty						July Month 18 Day 1968-10:15 M					
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS	
Male	White		August 11, 1903			64 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
W. Va.		USA				Allegany Md					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cumberland			D.O.A. Memorial H.			House Inspector			Municipal		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.			Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1100 Oldtown Road		
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
William					Leighty	Sarah Ellen Light					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT					
no						Mrs. Eva Leighty, Cumberland, Md. Wife					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>										24 days	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Or very severe</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
4) 1											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION			Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>6/29/68</i> , 19__, to <i>7/16/68</i> , 19__, that (I) <i>two</i> last saw the deceased alive on <i>7/16/68</i> , 19__, and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>two</i> did <i>(did not)</i> view the body after death.											
22b SIGNATURE			DEGREE			ATTENDING PHYS.			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
<i>Dr. Richard F. Williams</i>									22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)			22b. ADDRESS								
Dr. Richard F. Williams, MD			122 S. Centre St., Cumberland, Md.								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			July 21, 1968			Hillcrest Burial Park			Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
James F. Scarpelli, Cumberland, Md.						DATE JUL 23 1968			<i>J. Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

69296

283

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print) <b>Elizabeth</b>			First Middle Last <b>Linn</b>			2a. DATE KNOWN OF DEATH Month Day Year <b>July 1 1968</b>			2b. HOUR 1A M			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Oct. 17, 1888</b>		6 AGE (In years last birthday) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Allegany</b> Md			
10 CITY OR TOWN OF DEATH <b>Cumberland</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>127 Race St.</b>			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>Housewife</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b COUNTY <b>Allegany</b>			13c CITY OR TOWN <b>Cumberland</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME <b>August Krause</b>			First Middle Last			15 MOTHER'S MAIDEN NAME <b>Margaret Books</b>			First Middle Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b SOCIAL SECURITY NO (If yes give war or dates of service)			17 INFORMANT <b>Mr. Kenneth Fuller, Cumberland, Md.</b>			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>+201</b>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day Year HOUR A.M. P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>July 1, 1968</b>				
ADDRESS (Street, city, town, or county) <b>Cumberland, Md.</b>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>July 2, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						ADDRESS			25a. REC'D BY REGISTRAR <b>JUL - 3 1968</b>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VE 1-10-68  
304 REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09297

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <b>HUBERT S. LOVENSTEIN</b>			2a. DATE OF DEATH Month Day Year <b>July 2 1968</b>			2b. HOUR <b>8<sup>45</sup> P M</b>						
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 18, 1892</b>		6. AGE (In years lost birthday) <b>76 YRS.</b>		7. UNDER 1 YEAR MONTHS DAYS <b>76</b>		8. UNDER 24 HRS HOURS MIN <b>8<sup>45</sup> P M</b>		
7a BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany Md</b>						
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>417 Magruder St.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>G. W. Helme</b>						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>417 Magruder St.</b>				
14. FATHER'S NAME First Middle Last <b>Andrew S. Lovenstein</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Magaret Kearns</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>WWI</b>			16b. SOCIAL SECURITY NO. <b>7-71</b>			17. INFORMANT <b>George Lovenstein</b>			Address <b>Cumberland Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal congestive heart failure</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>H. &amp; A.S. Cardiovascular disease with atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>myocardial infarction 1956</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7-71 Bronchiogenic carcinoma L. lung, atherosclerosis 2 1/2 years</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. F. YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or RFD No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>June 19 56</b> , to <b>2 July 1968</b> , that (I) (we), last saw the deceased alive on <b>2 July 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>W. Alfred Van Ormer, M.D.</b>			22c. DATE SIGNED <b>3 July 68</b>			22d. PHYSICIAN'S NAME (Type) <b>W. ALFRED VAN ORMER</b>						
22e. ADDRESS <b>MEDICAL BUILDING, CUMBERLAND, MD.</b>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7/5/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md.</b>			
24. FUNERAL DIRECTOR <b>Louis Stein Inc.</b>			ADDRESS <b>Cumberland Md.</b>			25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

09298

1. DECEASED NAME (Type or print) <b>RUTH E. LOWRY</b>			2a. DATE OF DEATH <b>7</b> Month <b>18</b> Day <b>68</b> Year		2b. HOUR <b>3:10</b> M
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>5 14 03</b>		6. AGE (In years last birthday) <b>65</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>PA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>ALLEGANY</b> Md.		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>	12a. USUAL OCCUPATION (Kind of work done during last year, even if retired) <b>POSTMASTER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>POSTMASTER</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>PA.</b>		13b. COUNTY <b>Somerset</b>	13c. CITY OR TOWN <b>FAIRHOPE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last <b>JOSEPH LOWRY</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>LYDIA BAKER LOWRY</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>171 14 7859</b>	17. INFORMANT Address <b>SACRED HEART HOSPITAL -900 SETON DRIVE CUMBERLAND, MARYLAND</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cx of Pancreas with</b> DUE TO, OR AS A CONSEQUENCE OF <b>prolonged metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>157X</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-1-68</b> , 19 <b>68</b> , to <b>July 18, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 15, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Blane Schindler</b>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/19/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. BLANE SCHINDLER</b>		22e. ADDRESS <b>43 GREENE ST., CUMBERLAND, MD. 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 22, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sts. Philip &amp; James Meyersdale, Somerset, Pa.</b>		23d. LOCATION (City or Town) (County) (State) <b>Somerset, Pa.</b>
24. FUNERAL DIRECTOR <b>Harvey H. Zeigler, Hyndman, Pa.</b>		25a. REC'D BY REGISTRAR <b>JUL 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09299  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>JAMES T. LYNCH</b>			2a. DATE OF DEATH <b>JULY 17, 1968</b>		2b. HOUR <b>4:20 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>12-25-98</b>		6. AGE (In years last birthday) <b>69</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CELANESE-RETIRED</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>CUMBERLAND</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME First Middle Last <b>JOHN THOMAS LYNCH</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARGARET FLOOD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-07-3328</b>		17. INFORMATION <b>SACRED HEART HOSPITAL CUMBERLAND, MD. 21502</b> <b>PATIENT RECORD 900 SETON DRIVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperkalemia and arteriosclerotic Cardiovascular disease &amp; failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>443x</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>7/17, 1968</u> , that (I) (we) last saw the deceased alive on <u>7/17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Heinrich UD</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/15/68</u>	
22d. PHYSICIAN'S NAME (Type) <b>S.G. WEISMAN M.D.</b>		22e. ADDRESS <b>GREENE STREET CUMB., MD. 21502</b> <b>59 BREN</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/19/1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SS Peter &amp; Paul Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Alleg Md.</b>	
24. FUNERAL DIRECTOR <u>Charles E. Hafer</u>		ADDRESS <b>Charles E. Hafer, 230 Balto Ave., Cumberland</b>		25a. REC'D BY REGISTRAR <b>JUL 19 1968</b>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

Y

Y

Y

Y

Y

Y

Y

Y

Y

Y

Y

Y

Y

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09300					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED NAME (Type or Print)			First William			Middle Bruce			Last Lynn			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 7-13-68		2b. HOUR 15a M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH Sept. 23, 1936		6 AGE (in years) 31 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year JULY 13, 1968		2d. HOUR 15a M	
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany			
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital--DOA				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Research Engineer				12b. KIND OF BUSINESS OR INDUSTRY Ballistic			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.				13b. COUNTY Allegany				13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2 Bel Air Court			
14. FATHER'S NAME First Middle Last William R. Lynn				15. MOTHER'S MAIDEN NAME First Middle Last Marion G. Goodyear											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				(If yes give war or dates of service) Reserves				16b. SOCIAL SECURITY NO. 233-58-3152		17. INFORMANT ADDRESS Mrs. Betty Jane Lynn, Bel Air, Md.--Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) RUPTURED HEART DUE TO, OR AS A CONSEQUENCE OF CRUSHED CHEST (AUTOMOBILE ACCIDENT) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
												H			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 3:15 P.M. 7-13-68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1b.) Driver of single car accident							
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt. 28, W. Va. 2 miles north of Fort Ashby, Mineral, W. Va.				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												22b. DATE SIGNED July 13, 1968			
ACTUAL SIGNATURE Benedict Skitarelic				EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE July 15, 1968				23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery				23d. LOCATION (City or Town) (County) (State) Cumberland Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarcelli, Cumberland, Md.				25a. RECEIVED BY REGISTRAR DATE JUL 17 1968				25b. REGISTRAR'S SIGNATURE Charles Judge							

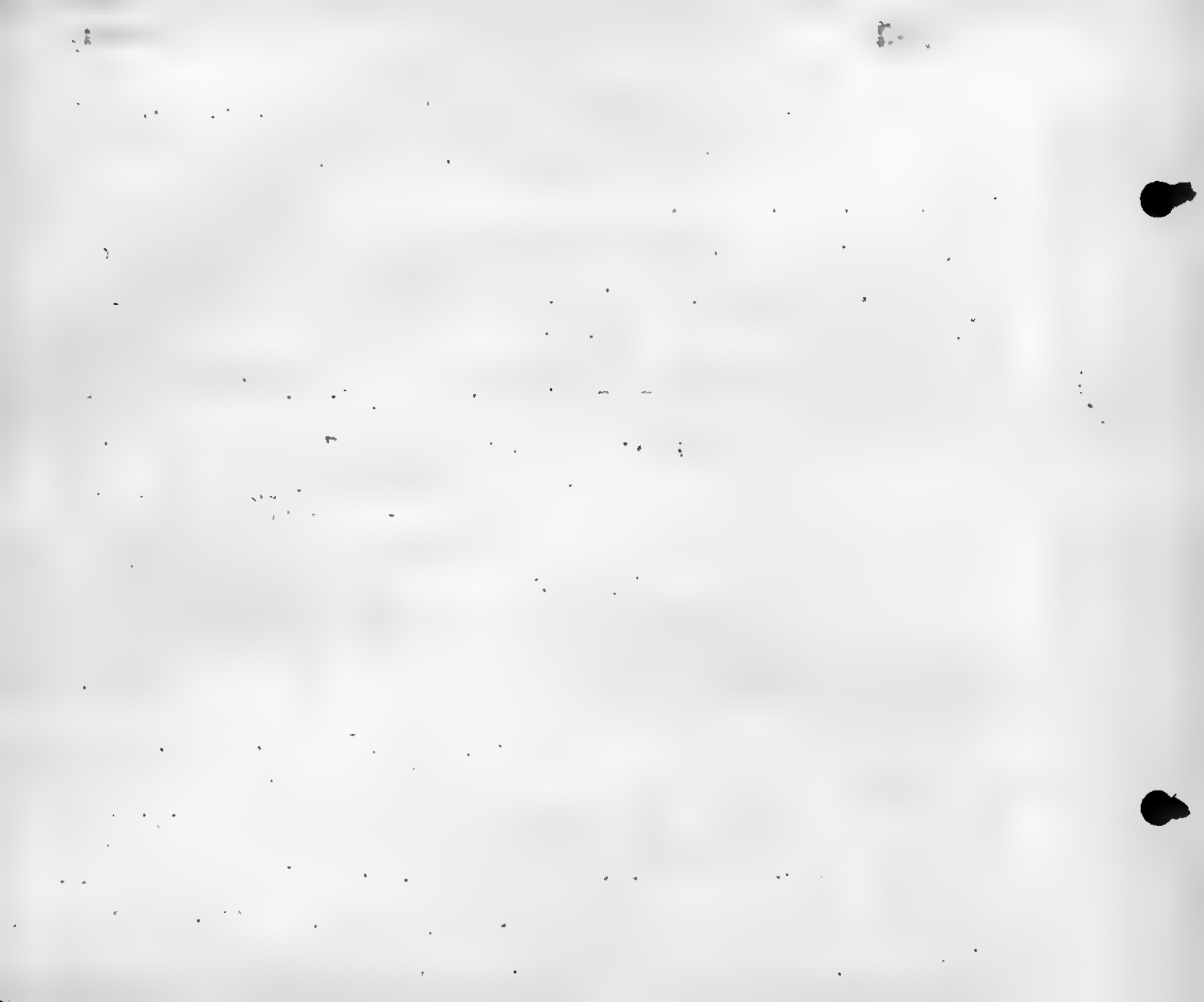




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
293											
09301											
1. DECEASED-NAME (Type or print) First Middle Last <b>KEARON MICHAEL MANNING</b>						2a. DATE OF DEATH Month Day Year <b>JULY 15, 1968</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JANUARY 8, 1884</b>		6. AGE (In years last birthday) <b>84</b> YRS.		7. IF UNDER YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>ELK GARDEN, W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.					
10. CITY OR TOWN OF DEATH <b>FROSTBURG</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MINERS HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MINER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>COAL</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>FROSTBURG</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>152 CENTRE STREET</b>			
14. FATHER'S NAME First Middle Last <b>JOHN MANNING</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY LANNON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. (If yes give complete date of service) <b>N.A.</b>		17. INFORMANT <b>FROSTBURG, MD. 21532</b>		17. INFORMANT <b>MRS. ANNIE KIGHT, 152 CENTRE ST.</b>					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>arterio-sclerotic heart disease</b> <b>4121</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Acute upper respiratory infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Empyema</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>1 wk.</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Seriously</b>											
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <b>6-16, 1968</b> , to <b>7-15, 1968</b> , that (I) (we) last saw the deceased alive on <b>7-14, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>H.C. Diehl M.D.</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/16/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>H. C. DIEHL, M.D.</b>		22e. ADDRESS <b>39 W. MAIN ST., FROSTBURG, MD.</b>		22f. ADDRESS <b>21532</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7/17/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAELS CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, ALLEGANY, MD.</b>					
24. FUNERAL DIRECTOR <b>MARILYN M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG</b>		25a. REC'D BY REGISTRAR <b>JUL 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



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VR A15 (4)  
30M REV 1/68

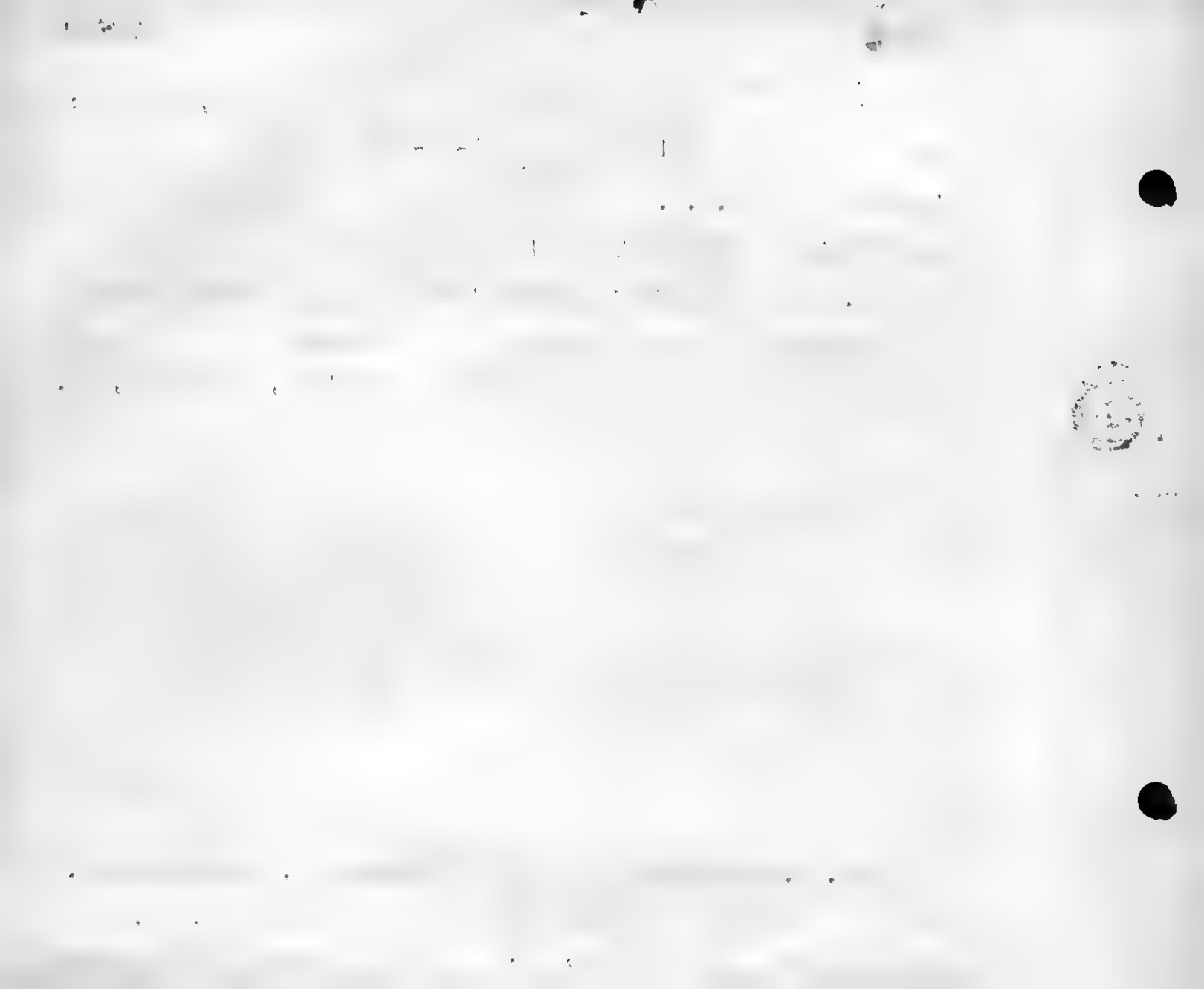
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09302

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First <b>PATRICK</b>		Middle	Lost <b>MC DONOUGH</b>		2a. DATE OF DEATH Month Day Year <b>JULY 28, 1968</b>		2b. HOUR <b>4:30PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>3-14-1909</b>		6. AGE (In years last birthday) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>ALLEGANY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.				
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>MD.</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>LONA CONING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>12 JACKSON STREET</b>		
14. FATHER'S NAME First Middle Lost <b>PATRICK MC DONOUGH</b>		15. MOTHER'S MAIDEN NAME First Middle Lost <b>MARGARET STAKEM</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (or unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>						
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4369</b> IMMEDIATE CAUSE (a) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>331X</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>July 28, 1968</b> to <b>July 28, 1968</b> , that (I) (we) lost saw the deceased alive on <b>July 28, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>DR. B. SCHINDLER</b>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/1/9/10</b>				
22d. PHYSICIAN'S NAME (Type) <b>DR. B. SCHINDLER</b>		22e. ADDRESS <b>43 GREENE ST., CUMBERLAND, MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/31/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>				
24. FUNERAL DIRECTOR <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

MEDICAL CERTIFICATION

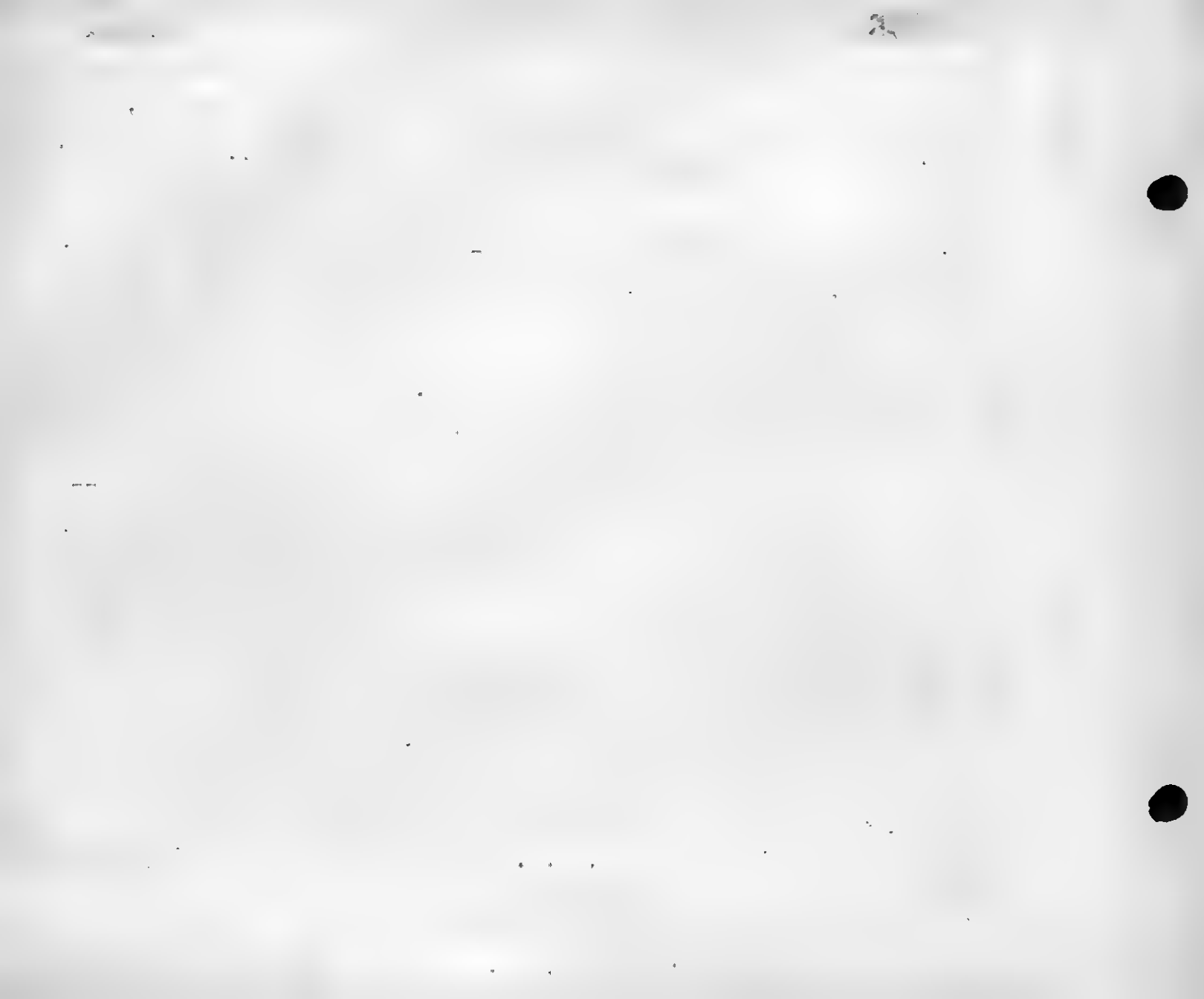


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) First Middle Last <b>Mary Catherine McGraw</b>						2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>JULY 8, 1968</b>			2b. HOUR <b>4:50 P.M.</b>		
3 SEX <b>Female</b>		4. RACE <b>White</b>		5 DATE OF BIRTH <b>July 18, 1910</b>		6 AGE (in years last birthday) <b>57 YRS</b>		7 UNDER 24 HRS MONTHS DAYS HOURS MIN <b>19</b>		2c. DATE PRONOUNCED DEAD Month Day Year <b>JULY 8, 1968</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b>			2d. HOUR <b>4:50 P.M.</b>		
10 CITY OR TOWN OF DEATH <b>Cumberland</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial Hospital-DOA</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>A Ave. Potomac Park</b>	
14. FATHER'S NAME First Middle Last <b>M G VanMeter</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Belle (Brotemarkle)</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO (If yes give war or dates of service) <b>None</b>			17. INFORMANT <b>Wesley A. McGraw</b>			ADDRESS <b>A Ave Potomac Park Cumberland, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b> <b>1970</b> DUE TO, OR AS A CONSEQUENCE OF <b>TUMOR EMBOLUS FROM LEFT KIDNEY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>CARCINOMA OF LEFT KIDNEY</b> DUE TO, OR AS A CONSEQUENCE OF <b>MONTHS</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>JULY 8, 1968</b>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ADDRESS (Street, city, town, or county) <b>CUMBERLAND, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Jul. 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md.</b>			
24. FUNERAL DIRECTOR <b>William G. Kight</b>				ADDRESS <b>Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09304							
CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR					
Mary Ethel Miller									July 21, 1968			6 PM					
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN						
F		W		Aug. 6, 1894			73 YRS.										
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.					
Md.			USA					Allegany									
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
Frostburg			201 Centennial Ext.			Housewife			Own Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER							
Md.			Allegany			Frostburg				201 Centennial Ext.							
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First		Middle		Last	
William T. Stanton									Annie Mary Durst								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO.			17. INFORMANT											
No			218-16-3477			Mrs. Vera Walker, 206 Armstrong Ave. Frostburg, Md.											
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>H CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 hr - years -</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)																	
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f LOCATION Street or R.F.D. No		City or Town		County		State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> to <u>July 21</u> 19 <u>68</u> , that (I) ( <u>we</u> ) lost saw the deceased alive on <u>July 18</u> 19 <u>68</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>do</u> ) ( <u>did not</u> ) view the body after death.																	
22b SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)		22e ADDRESS		22f MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22g. DATE SIGNED					
John B. Davis		7/23/68				John B. Davis, MD		Frostburg, Md.				7/23/68					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)							
Burial		7/24/68		Grantsville Cem		Grantsville		Corryett, Md.									
24 FUNERAL DIRECTOR		24b ADDRESS		24c. REC'D BY REGISTRAR		24d REGISTRAR'S SIGNATURE		24e DATE		24f							
Kurt Neuman		Grantsville, Md.		JUL 29 1968		Charles Judge											





MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09305

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b AM
Nora		Bell	Miller		ESTIMATED		7	6	1968	11:30
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS	8 MONTHS	9 DAYS	10 HOURS	11 MIN	2c DATE PRONOUNCED DEAD	2d AM
Female	White	Jan. 17, 1895	73 YRS						7	11:30
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
Penna.		USA				Allegany				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY				
Flintstone		RFD # 2 Flintstone, Md.		Housekeeper		Home				
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.		Allegany		Flintstone		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD # 2		
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
Daniel		Beck		Emma Mauk						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, type or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT						
No		212-32-8380		RFD # 2 ADDRESS Robert E. Miller Flintstone, Maryland						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot of Chest										Minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
(b) (Self Inflicted)										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
26x										
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B)						
		19 P.M.								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED				
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		July 6, 1968				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		CUMBERLAND, MARYLAND		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		July 9, 1968		Pleasant Grove Cemetery		Rt #2 Flintstone Allegany Maryland				
24. FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
H. Lee Silcox 404 Decatur St., Cumb., Md.				JUL 11 1968		Charles Judge				

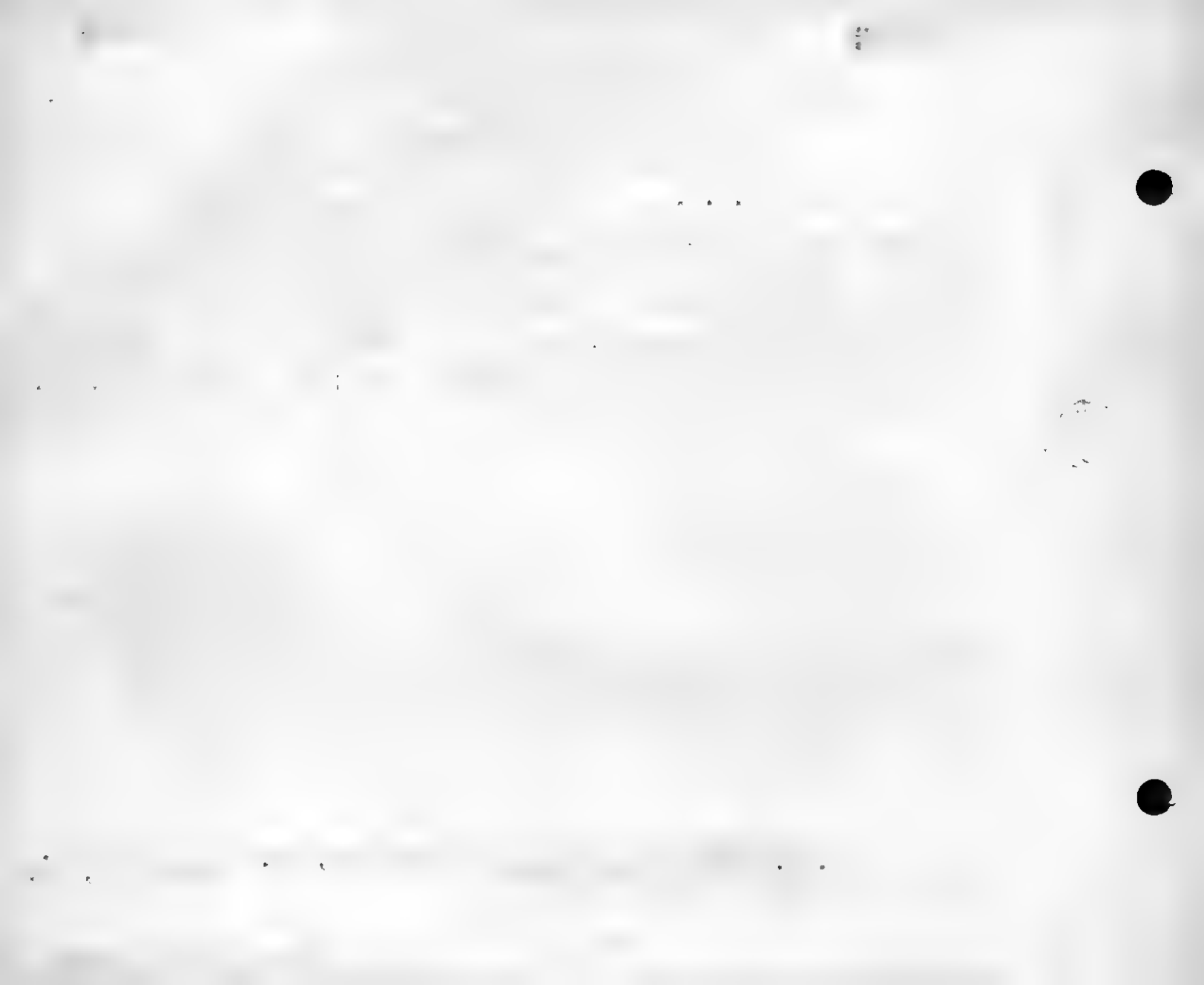


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304A REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09306										
1 DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
BOY (John Walter) MORRISON					Month 7 Day 21 Year 68			2:12 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER 1 YEAR		
MALE		WHITE		7-20-68		YRS.		MONTHS DAYS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
MARYLAND		U.S.A.				ALLEGANY				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL			none		none		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.			Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Parent's Address, Oldtown, Md.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
First Middle Last WILLIAM MORRISON				First Middle Last CAROL RIDENBAUGH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17 INFORMANT				
						MEMORIAL HOSPITAL CUMBERLAND, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Immaturity</u>										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Robert Dawson MD</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED			
22d PHYSICIAN'S NAME (Type) DR. XXXXXXXX ROBERT DAWSON					22e ADDRESS XXXXXXXX XXXX		500 GREENE ST. CUMBERLAND, MD.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		July 23, 1968		Restlawn Gardens		La Vale, Md. Allegany				
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
					DATE JUL 31 1968		<u>Charles Judge</u>			



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09307  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month 1 Day 1968 Year		2b. HOUR 11 A. M.		
CORLISTA		B.		MURPHY					
3. SEX FEMALE	4. RACE WHITE		5. DATE OF BIRTH JUNE 20, 1872		6. AGE (In years last birthday) 96 YRS.		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ROBERTS PLACE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution) admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROBERTS PLACE	
14. FATHER'S NAME First Middle Last SAMUEL W. GROGHAN		15. MOTHER'S MAIDEN NAME First Middle Last PRISCILLA POLING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 185-38-8940-J1		17. INFORMANT Address GEORGE MURPHY, MEYERSDALE, PA.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arterio-sclerotic heart disease</u> 4124 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Senility</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-2</u> , 19 <u>68</u> , to <u>7-1</u> , 19 <u>68</u> , that (I) ( <u>we</u> ) lost saw the deceased alive on <u>6-26</u> , 19 <u>68</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) ( <u>did not</u> ) view the body after death.									
22b. SIGNATURE <u>H. C. Diehl, M.D.</u>		22c. DATE SIGNED 7-2-68		22d. PHYSICIAN'S NAME (Type) H. C. DIEHL, M. D.					
22e. ADDRESS 39 W. MAIN ST., FROSTBURG, MD. 21532									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 3 '68		23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		23d. LOCATION (City or Town) (County) (State) GARRETT COUNTY, MD.			
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR JUL - 5 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 4 and 5) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09308
Item 6, Film G402 7/12/68 km										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First <b>NINA</b>		Middle <b>A</b>		Last <b>MURPHY</b>		2a. DATE OF DEATH Month <b>JULY</b> Day <b>2</b> Year <b>1968</b>		2b. FROM <b>5:17 PM</b>
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>10-23-1911</b>		6 AGE (In years) Last birthday <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS <b>5</b> DAYS <b>17</b>		IF UNDER 24 HRS. HOURS <b>5</b> MIN <b>17</b>
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.A.</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>		Md.		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during usual working life, even if retired.) <b>WIFE.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>LAVALE</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>625 BRADDOCK AVE.</b>		
14. FATHER'S NAME First <b>JERRY</b> Middle <b>SWEITZER</b> Last <b>SWEITZER</b>		15. MOTHER'S MAIDEN NAME First <b>MARTHA</b> Middle <b>FRIEND</b> Last <b>FRIEND</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic C.V. disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary of both hearts</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>Several yrs</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>June 7, 1968</b> to <b>July 2, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Thomas F. Lewis M.D.</b>		22c. DATE SIGNED <b>7/5/68</b>								
22d. PHYSICIAN'S NAME (Type) <b>DR. THOMAS F. LEWIS</b>		22e. ADDRESS <b>CUMBERLAND, MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jul 6, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md</b>				
24. FUNERAL DIRECTOR <b>William G. Kight</b>		ADDRESS <b>Cumberland, Md</b>		25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				





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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
MURPHY			WILLIAM J.			7 Month 27 Day 68 Year		6:20 PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
MALE		WHITE		2-1-93		75 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MASS.		USA				ALLEGANY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			SACRED HEART HOSP.					N.Y. TRANSIT		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
W. VA.					DAVIS		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		HENRY AVENUE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
PATRICK J. MURPHY			ELLEN HARRINGTON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
YES			081-20-7375		HOSP. REC. CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) BLANE SCHINDLER, M.D.					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		July 30, 1968		Mount Calvary		Thomas, West Virginia				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
HINKLE FUNERAL HOME		DAVIS, W. VA.		AUG 5 1968		J. Charles Judge				



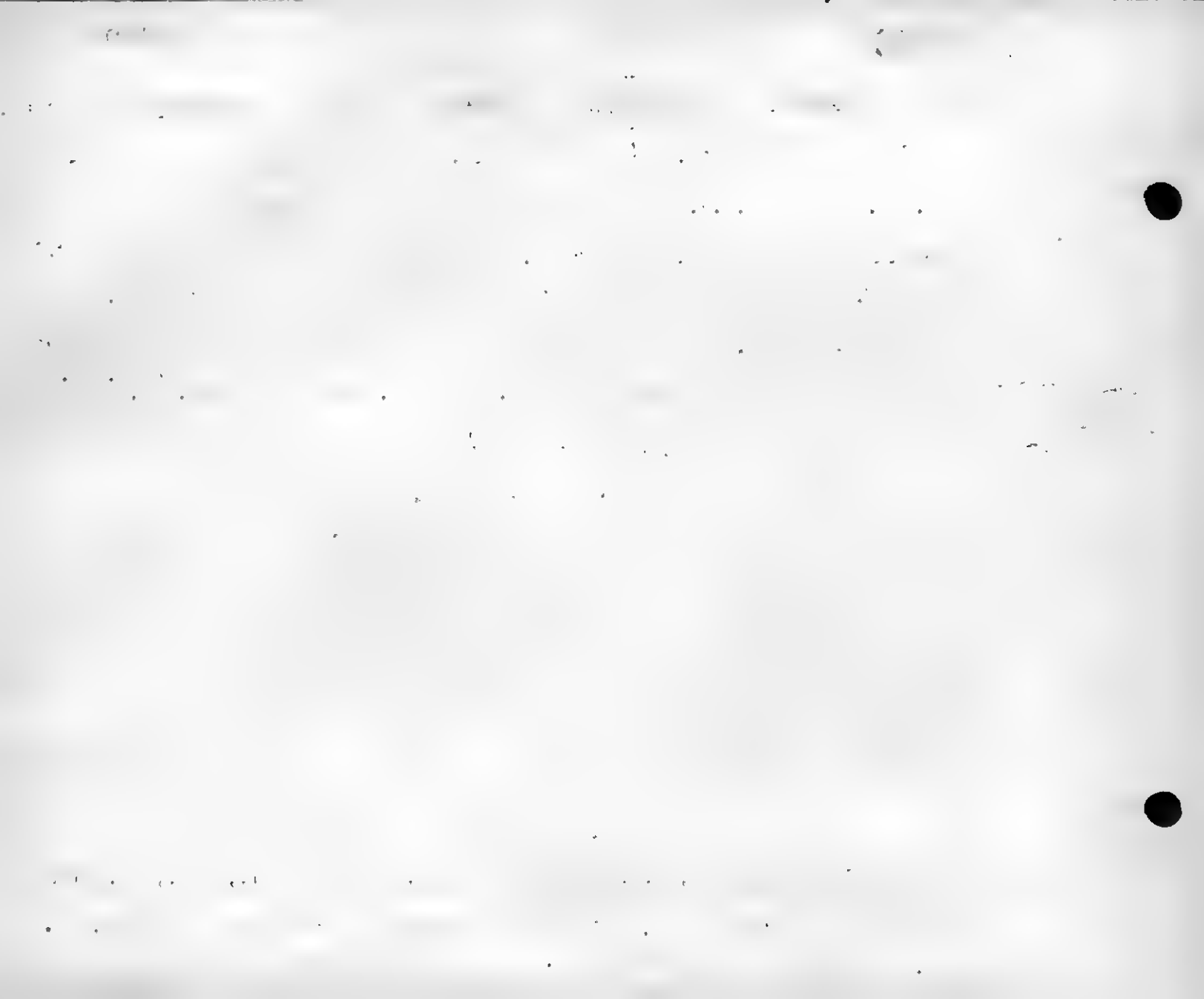
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09302

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201-9310  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Joseph Robert Neely</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>22</b> , Year <b>1968</b>		2b. HOUR <b>6:00P.</b>
3 SEX <b>Male</b>	4 RACE <b>Cau.</b>	5. DATE OF BIRTH <b>Dec. 24, 1899</b>		6 AGE (In years lost birthday) <b>68</b> YRS.	+ UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Allegany</b> Md.		
10 CITY OR TOWN OF DEATH <b>Cumberland</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>115 Cumberland St.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Mail Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>115 Cumberland St.</b>	
14 FATHER'S NAME First <b>William</b> Middle <b>A.</b> Last <b>Neely</b>	15. MOTHER'S MAIDEN NAME First <b>Rebecca</b> Middle <b>Whisner</b> Last <b>Whisner</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No, (or unknown) <input type="checkbox"/> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO <b>216-44-7676</b>	17. INFORMANT Address <b>Cumb. Md. 115 Cumb. St.</b> <b>Mr. George E. Neely</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mysocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arterio-sclerosis Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arterio-sclerosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4109</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>C. Vincent M.D.</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>CLARENCE VINCENT, M.D.</b>		22e. ADDRESS <b>126 N. SMALLWOOD ST., CUM., MD. 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/25/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany, Md.</b>		
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	25a. REC'D BY REGISTRAR <b>JUL 29 1968</b> DATE	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09311											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR		
VIRGINIA			NEWMAN			July 3 1968			1:30 A		
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Female		White		October 10, 1879			88 YRS				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.A.						Allegany Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			527 Maryland Ave			Housekeeper- At Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY - IN 157? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Allegany			Cumberland				JFK Homes. 135 N. Mechanic Street	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Harvey <del>XXXXX</del> Robinette <del>XXXXXX</del>			Katherine Gibson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No						Mrs. S.C. Thom			33 N. Mechanic St Cumberland, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis - Senility</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4500</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral Embolism - Radiation Therapy</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>ST. Mary, 1968</u> to <u>3 July, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Fuller B. Whitworth</u>						DEGREE ATTENDING PHYS		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/3/68	
22d. PHYSICIAN'S NAME (Type) Fuller B. Whitworth M.D.						22e. ADDRESS 305 Washington St Cumberland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		7/5/68		S.S. Peter & Paul Cemetery			Cumberland Allegany Maryland				
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland Maryland 21502						25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



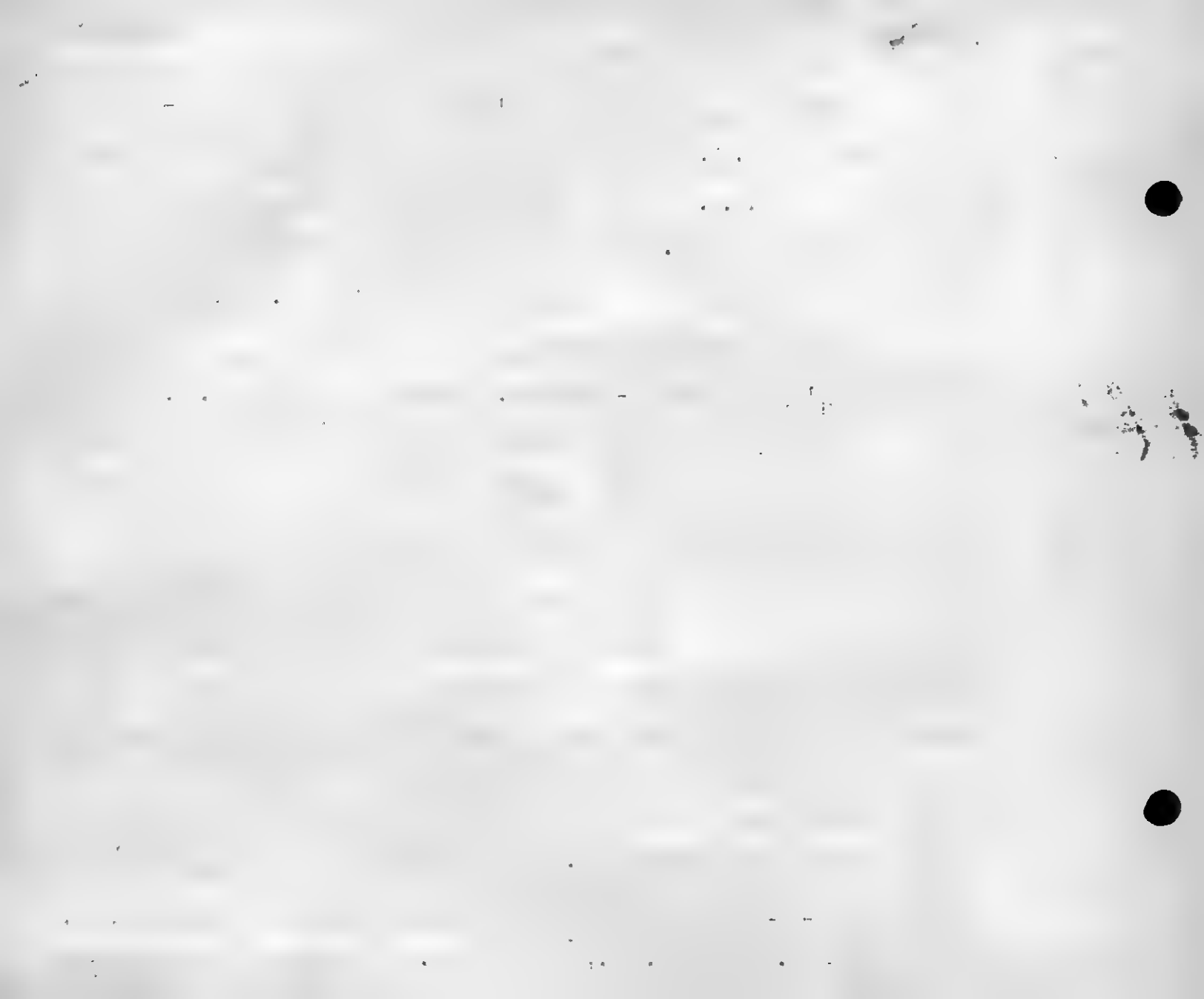
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the body. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
CHARLES WILLIAM O'DONNELL						Month Day Year 7 - 14 1968			4 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD	2d. HOUR
Male	White	Dec. 1, 1897	70 YRS					Month Day Year July 14 1968	4 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Allegany Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Rural Cumberland			Rt. 1, Locust Grove			Auto mechanic			Bakery
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Allegany		Cumberland	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. # 1, Locust Grove	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Charles William O'Donnell			Margaret Villiard						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
Yes Aug '17 to Dec '18			217-10-1341		Mrs. Catherine O'Donnell, Rt. #1, Locust Grove Cumberland, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION								SUDDEN	
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS								YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
Benedict Skitarelic			M.D.			July 14, 1968			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
Benedict Skitarelic, M.D.			Cumberland, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		7-17-68	Sunset Memorial Gardens			Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John J. Hafer, Jr., 230 Balto. Ave., Cumberland, Md.					JUL 18 1968		Charles Judge		





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 116-1  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

69312

1 DECEASED NAME (Type or print) <b>FORREST</b>		First <b>FORREST</b>		Middle <b>V.</b>		Last <b>PAIGE</b>		2a. DATE OF DEATH Month <b>JULY</b> Day <b>3</b> Year <b>1968</b>			2b HOUR <b>10:50</b>	
3 SEX <b>MALE</b>		4 RACE <b>COLORED</b>		5 DATE OF BIRTH <b>DEC. 1, 1911</b>			6 AGE (In years last birthday) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b>					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>LABORER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>224 CARROLL ST.</b>				
14. FATHER'S NAME First <b>GEORGE</b> Middle <b>A.</b> Last <b>PAIGE</b>		15 MOTHER'S MAIDEN NAME First <b>IOLA</b> Middle <b>Males</b> Last <b></b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-05-5292</b>		17. INFORMANT Address <b>HOSP. RECORD, CUMBERLAND, MD.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>with metastatic tumor liver metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>150X</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>6/17</b> , 19 <b>68</b> , to <b>July 3</b> , 19 <b>68</b> ; that (I) (we) lost the deceased alive on <b>July 3</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Blane M. Schindler</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/4/68</b>						
22d. PHYSICIAN'S NAME (Type) <b>BLANE M. SCHINDLER, MD.D.</b>		22e. ADDRESS <b>43 GREENE ST., CUMBERLAND, MD.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/6/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md.</b>						
24. FUNERAL DIRECTOR <b>STEIN FUNERAL HOME</b>		24a. ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						

1. The first part of the paper is devoted to a general discussion of the problem of the existence of solutions of the system of equations

(1)  $\frac{dx}{dt} = f(x, y, z), \quad \frac{dy}{dt} = g(x, y, z), \quad \frac{dz}{dt} = h(x, y, z)$

where  $f, g, h$  are continuous functions of  $x, y, z$  and satisfy the conditions

(2)  $f, g, h$  are bounded in the region  $R$  of the phase space.

It is shown that under these conditions the system (1) has a solution in the region  $R$ .

2. In the second part of the paper the problem of the existence of solutions of the system of equations

(3)  $\frac{dx}{dt} = f(x, y, z), \quad \frac{dy}{dt} = g(x, y, z), \quad \frac{dz}{dt} = h(x, y, z)$

is considered, where  $f, g, h$  are continuous functions of  $x, y, z$  and satisfy the conditions

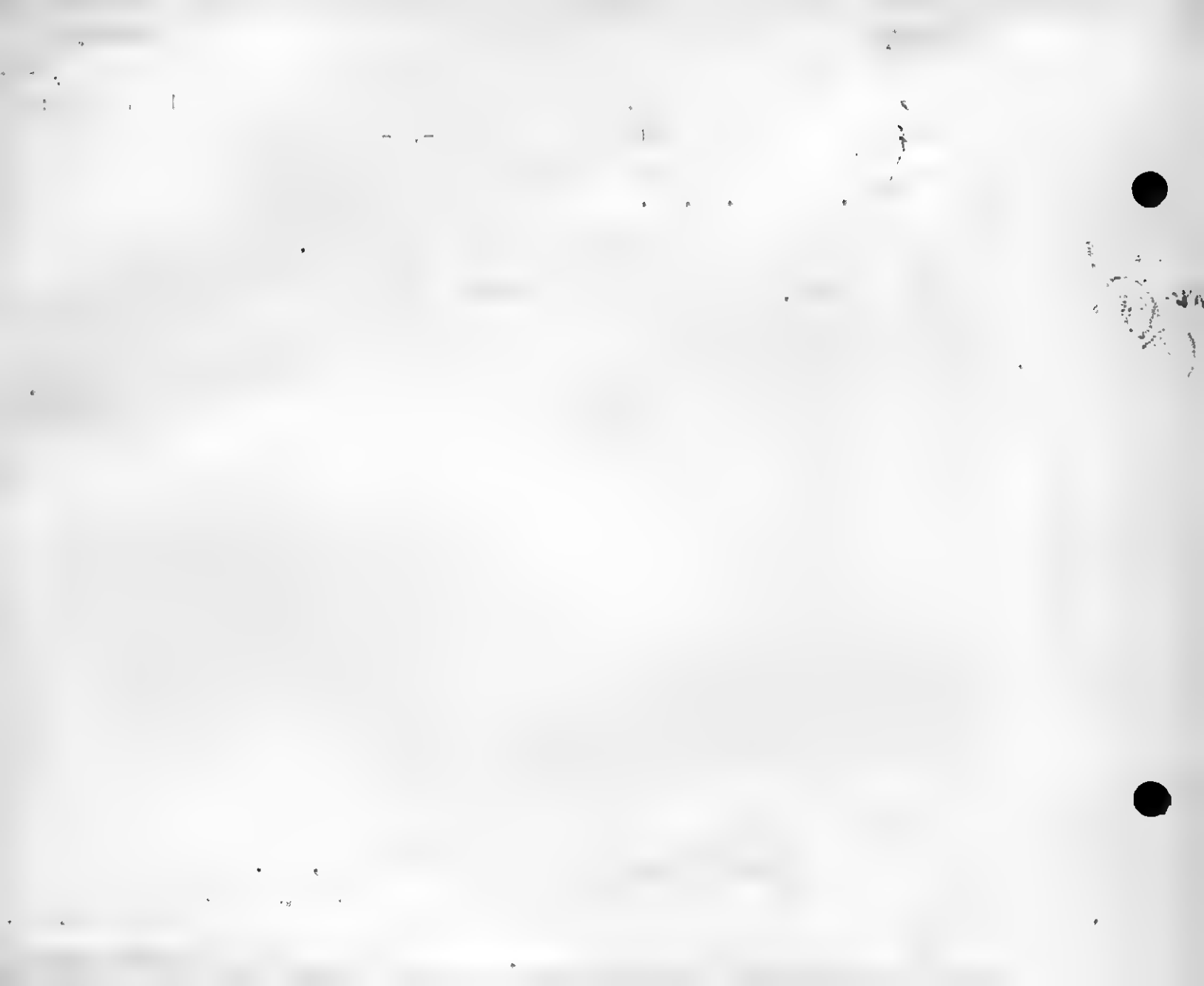
(4)  $f, g, h$  are bounded in the region  $R$  of the phase space.

It is shown that under these conditions the system (3) has a solution in the region  $R$ .

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
MINNIE B. PENSYL						JULY 31, 1968		3:30 P.M.	
3. SEX	FEMALE		4. RACE	WHITE		5. DATE OF BIRTH	6. AGE (In years last birthday)		7. IF UNDER 1 YEAR
						8-18-91	YRS		MONTHS
7a. BIRTHPLACE (State or foreign country)	PENN.		7b. CITIZEN OF WHAT COUNTRY?	U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH
							ALLEGANY		CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during months preceding life, even if retired)	HWY.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE	PENNA.		13b. CITY OR TOWN	BEDFORD HYNDMAN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
	William Henry		Aberle				Rachel Ellen		Bennett
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	No		16b. SOCIAL SECURITY NO	206-01-1150		17. INFORMANT Address			
						MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u>									3 mo.
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>Carcinoma of Colon</u>									5 yrs.
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Anterior resection</u>									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
Aug 1968	Carcinoma of Colon								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
	HOUR A.M. Month Day Year								
	P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY; OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No		City or Town		County
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>68</u> , to <u>7-31</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-31-68</u> , 19 <u>68</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
<u>DR. DONALD GROVE</u>					8-1-68				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
DR. DONALD GROVE					CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial	August 3, 1968		Hyndman Cemetery		Hyndman, Bedford Co.		PA		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Harvey H. Zeigler, Hyndman, Pa.					AUG 7 1968		<u>Charles Judge</u>		

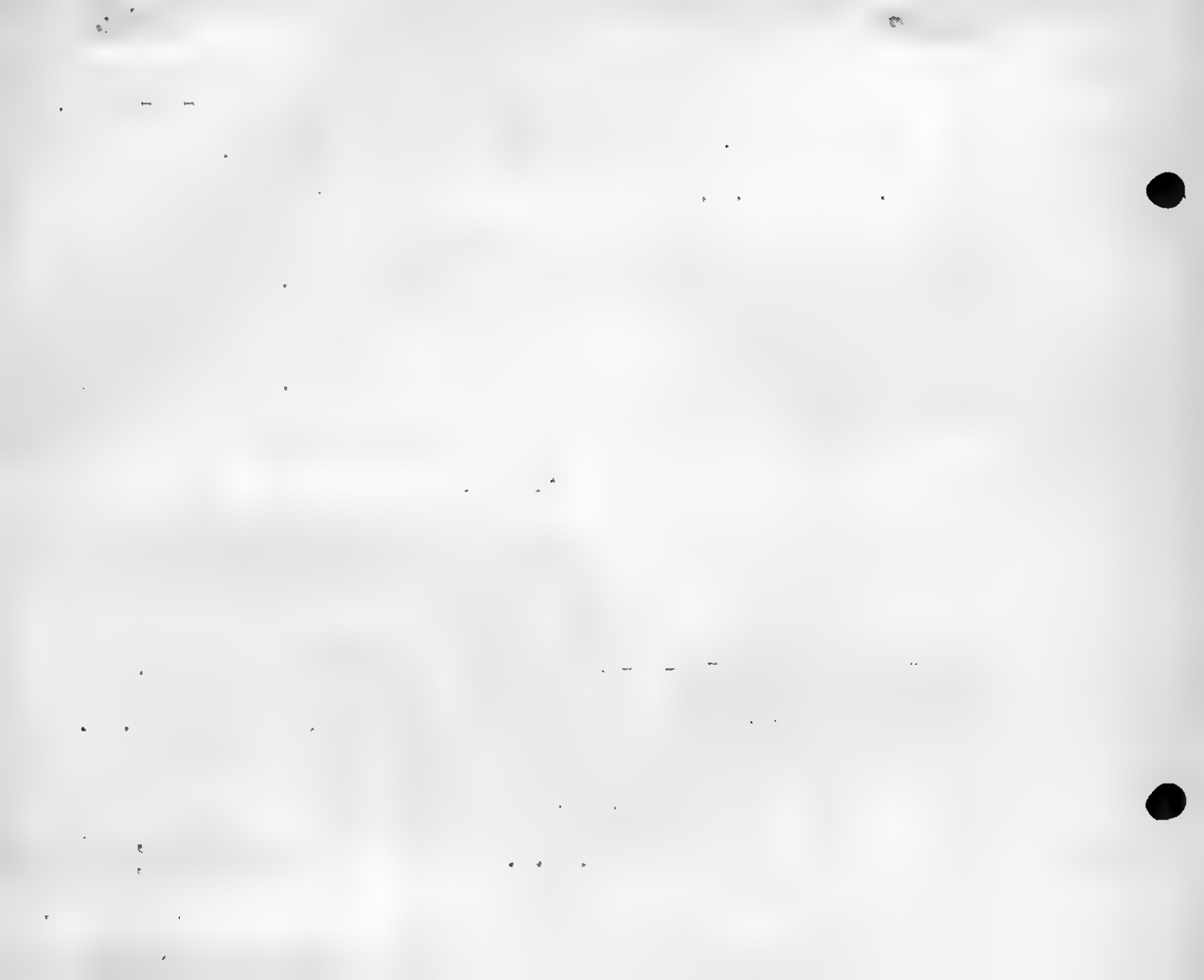


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										09315			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or Print)			First DONAVIN			Middle EUGENE			Last POLAND			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7-19-68 19 4:25 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 21, 1916		6. AGE (In years last birthday) 51 YRS		IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year July 9, 1968 19 4:25 PM	
7a. BIRTHPLACE (State or foreign country) W, Va.			7b. CITIZEN OF WHAT COUNTRY? U. S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Allegany Md				
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer				12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution, give address) STATE W, Va.				13b. COUNTY Hampshire				13c. CITY OR TOWN Romney		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 6	
14. FATHER'S NAME First Middle Last Alvin C. Poland						15. MOTHER'S MAIDEN NAME First Middle Last Edith Kline							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) NO				16b. SOCIAL SECURITY NO. 232-26-3212				17. INFORMANT Eugene Poland, Rt. 6, Romney, W, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemothorax, bilateral 2 Hours DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) } (b) Crushed Chest 2 Hours stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day Year HOUR AM PM 2:25 PM 7-19-68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Pinned under overturned farm tractor					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Farm				21f. LOCATION Street or R.F.D. No City or Town County State Route #6 Romney, Hampshire, W. Va.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED July 19, 1968					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE July 22, 1968		23c. NAME OF CEMETERY OR CREMATORY Hott's Chapel				23d. LOCATION (City or Town) (County) (State) Kirby Hampshire W, Va.			
24. FUNERAL DIRECTOR [Signature]						ADDRESS Romney, West Virginia		25a. REC'D BY REG. STRAR JUL 23 1968		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
ETHEL CORNELIA REDMOND						Month Day Year			7:40A <sup>M</sup>
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		* <del>WHITE</del> NEGRO		7-3-99		69 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
MARYLAND		U.S.A.				ALLEGANY Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL		RETIRED ELEVATOR OPERATOR		WARD			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				426 PINE AVENUE	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JOSEPH NMI TRENT			Martha Shamblin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
NO		216-22-6121		MEMORIAL HOSPITAL		CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) UREMIA - METABOLIC ACIDOSIS									7 WKS
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) MEMBRANOUS NEPHRITIS									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
593x HYPERTENSION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from JUNE 15 1968, to JULY 19 1968, that (I) (we) last saw the deceased alive on JULY 18 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		M.D. DEGREE		ATTENDING PHYS		MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
								7-19-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
DR. SAMUEL JACOBSON		CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		7/23/1968		Sumner Cemetery		Cumberland		Alleg	Md.
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Charles E. Hafer						JUL 22 1968			
Charles E. Hafer, 230 Balto Ave. Cumberland, Md.									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-1-68  
304 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First <b>Albert</b>	Middle <b>T.</b>	Last <b>Rice</b>	2a DATE OF DEATH Month <b>7</b> Day <b>5</b> Year <b>68</b>		2b HOUR P <b>1:30M</b>				
3 SEX <b>Male</b>		4 RACE <b>American (White)</b>		5 DATE OF BIRTH <b>6-21-1900</b>		6 AGE (In years lost birthday y) <b>68</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b>		Md.			
10 CITY OR TOWN OF DEATH <b>Cumberland, Md.</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cumberland Nurs. Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Carman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>219 Maple St.</b>			
14 FATHER'S NAME First <b>Alonza</b> Middle Last <b>Rice</b>		15 MOTHER'S MAIDEN NAME First <b>Meredith</b> Middle <b>Beall</b> Last <b>Bell</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>705-05-8554</b>		17 INFORMANT <b>Daughter</b> <b>Mrs. Betty Price</b>		17b. ADDRESS <b>Oldtown Road</b> <b>Cumberland, Md.</b>					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma Cordis End Stomach</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>A.S. Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 month.</b> <b>10 years</b> <b>18 years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Generalized arteriosclerosis</b>											
19a. DATE OF OPERATION		19b. COMBAT ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <b>68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , to <b>5 July, 1968</b> , that (I) (we) last saw the deceased alive on <b>3 July 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W.A. Van Ormer, M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6 July 68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Dr. W.A. Van Ormer, M.D.</b>		22e. ADDRESS <b>122 S. Centre St., Cumberland, Md.</b>									
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 8, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>					
24 FUNERAL DIRECTOR <b>James P. Scarpell</b>		ADDRESS <b>108 Virginia Ave.</b>		25a. REC'D BY REGISTRAR <b>JUL 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09818

Items#5&6 Film#G40 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <b>Abraham L. Robertson</b>			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>JULY</b> Day <b>20</b> Year <b>1968</b>		2b HOUR <b>6 a.m.</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>12/5/1896</b>	6 AGE (in years last birthday) <b>71</b> YRS	7c DATE PRONOUNCED DEAD Month <b>JULY</b> Day <b>20</b> Year <b>1968</b>	2d HOUR <b>6:30 A.M.</b>
7a BIRTHPLACE (State or foreign country) <b>MD.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Allegany</b> Md.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Centre Street</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD.</b>		13b COUNTY <b>Allegany Cumberland</b>		13c STREET AND NUMBER <b>**</b>	
14 FATHER'S NAME First <b>Charles</b> Middle <b>Robertson</b> Last <b>Robertson</b>			15. MOTHER'S M A DEN NAME First <b>Margaret</b> Middle <b>Thompson</b> Last <b>Thompson</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b SOCIAL SECURITY NO <b>218-01-7503</b>		17 INFORMANT ADDRESS <b>Margaret Taylor, Lonaconing, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b>					<b>SUDDEN</b>
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4109</b>					
(b) <b>CORONARY SCLEROSIS</b>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION <b>7/22</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>20 JULY 1968</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ADDRESS (Street, city, town, or county) <b>CUMBERLAND, MARYLAND</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>7/22/1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>	
23d LOCATION (City or Town) <b>Moscow, Allegany. MD.</b>		23e (County) <b>Allegany</b>		23f (State)	
24 FUNERAL DIRECTOR <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>		25a REC'D BY REG. STRAR <b>JUL 22 1968</b>	
				25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

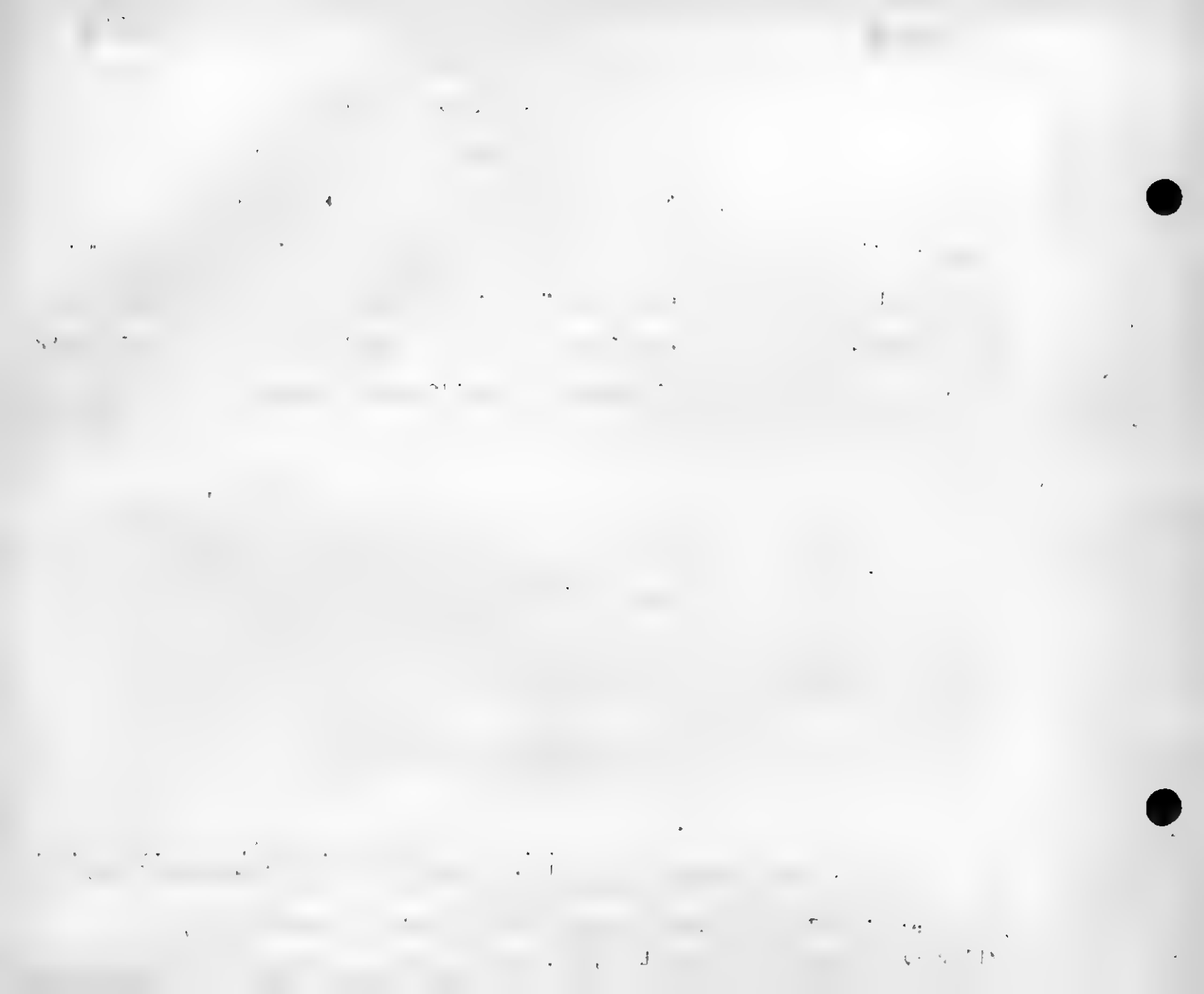
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

69319

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>OLIVER H. ROBERTSON</b>			2a. DATE OF DEATH Month <b>JULY</b> Day <b>25</b> Year <b>68</b>			2b HOUR <b>A M</b>					
3. SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUGUST 1, 1890</b>		6. AGE (In years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> M. N. <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY COUNTY</b> Md.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>CARPENTER</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>ROUTE 1, BOX 508</b>		
14. FATHER'S NAME First Middle Last <b>BENJAMIN ROBERTSON</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>EMOLINE MCCULLOUGH</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>217 14 4955</b>		17 INFORMANT Address <b>PATIENT'S HOSPITAL CHART</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized metastasis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Malignancy - Primary not found</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1992 Generalized Arteriosclerosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Clarence J. Vincent</u> M.D.		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) <b>DRXXXXSEXXXXX CLARENCE VINCENT</b>		22e. ADDRESS <b>126 N. SMALLWOOD ST., CUMB.MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JULY 27, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DAVIS MEMORIAL CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND MD.</b>					
24. FUNERAL DIRECTOR <b>KIGHT FUNERAL HOME</b>		ADDRESS <b>CUMBERLAND, MD. 21502</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 29 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



# FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

39320

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year			2b HOUR		
JOSEPH EDWARD ROUBAL						7-28-68			11:30 PM					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR			
MALE	WHITE	Sept. 2, 1946	22 YRS	MONTHS	DAYS	HOURS	MIN.	July 28, 1968			3:30 PM			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED			9. COUNTY OF DEATH					
CALIFORNIA			USA			NEVER MARRIED			ALLEGANY					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Near Cumberland, Md.			MEMORIAL HOSPITAL						2nd Class Petty Officer-U.S. Navy					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER		
Calif.						San Jose			YES			15720 Loma Vista Ave.		
14 FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last					
John A. Roubal						Kathleen Pherrill								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			18 ADDRESS					
yes			Present			Kathleen P. Graham, Santa Calif. Mother								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) HEMOTHORAX, BILATERAL												48 Hrs.		
DUE TO, OR AS A CONSEQUENCE OF														
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) FRACTURED RIBS, CONTUSIONS OF												"		
DUE TO, OR AS A CONSEQUENCE OF														
(c) MEDIASTINUM														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?						
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
				11:30 P.M. 7-25-1968				Driver of Car in single car accident						
21d INJURY OCCURRED				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Route #51, 7 Miles South of Cumberland, Allegany, Maryland										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b DATE SIGNED						
Benedict Skitarelic								JULY 28, 1968						
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)						
BENEDICT SKITARELIC, M.D.				CUMBERLAND, MARYLAND										
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY						
Burial				Aug. 2, 1968				Santa Clara Catholic Cem. Santa Clara, Calif.						
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REG. STRAR						
James F. Scarpelli, Cumberland, Md.								DATE AUG 8 1968						
								25b REGISTRAR'S SIGNATURE						
								Charles Judge						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

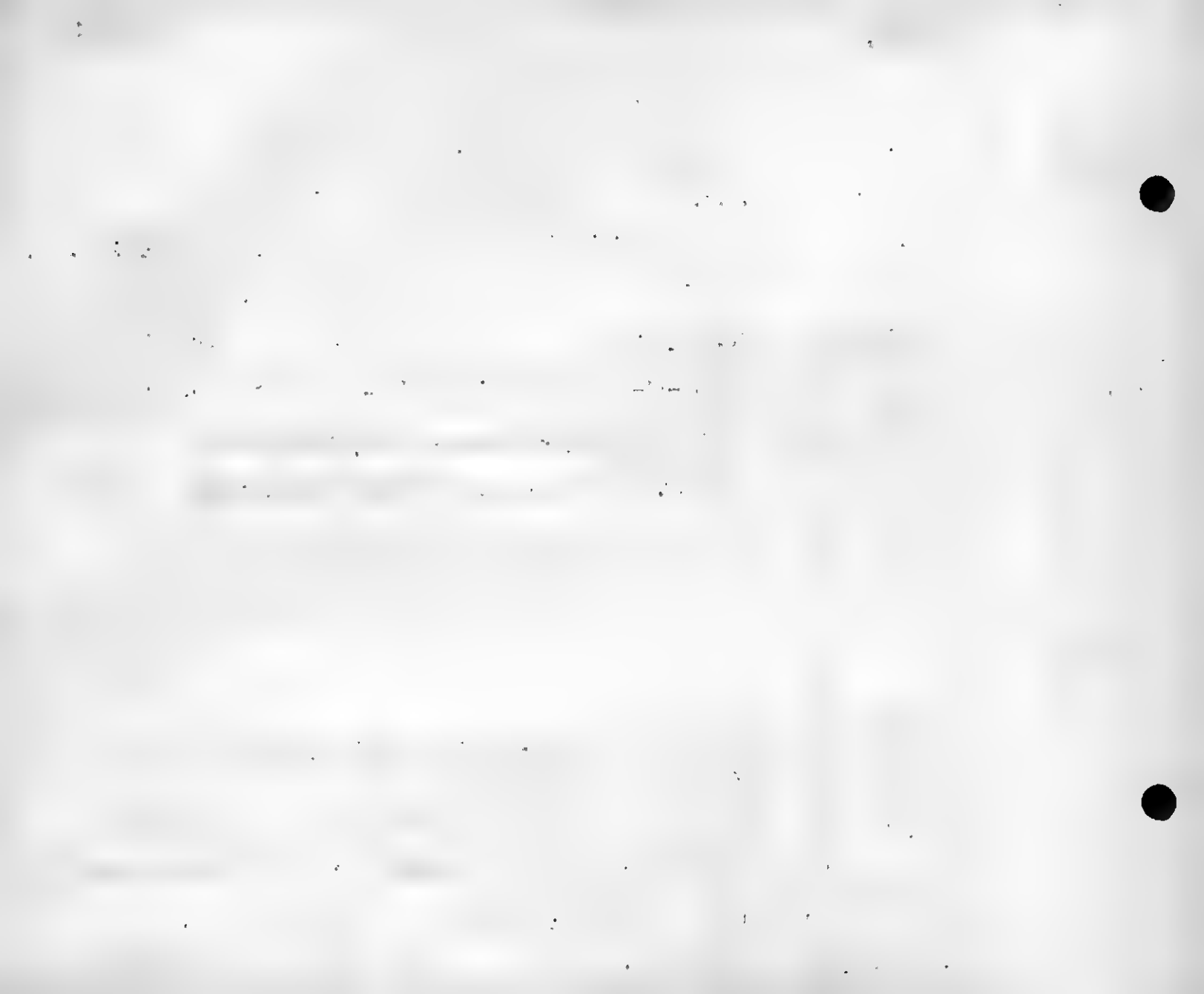




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

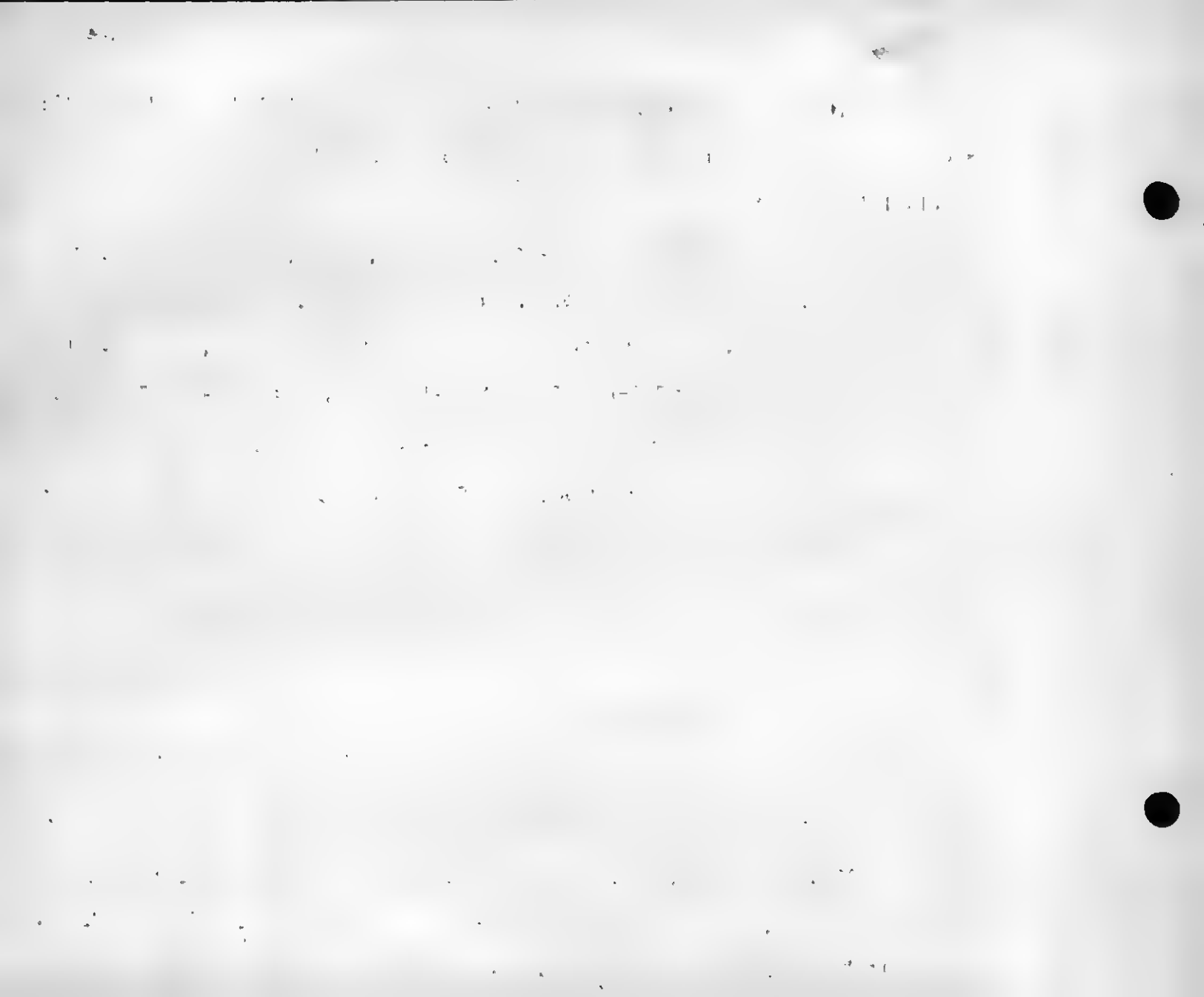
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
09321											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First <b>AGNES</b>		Middle <b>M.</b>		Last <b>RUGE</b>		2a. DATE OF DEATH <b>JULY</b> Month <b>1</b> Day <b>1968</b> Year		
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>DEC. 15, 1899</b>			6 AGE (In years last birthday) <b>68</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY</b>					
10 CITY OR TOWN OF DEATH <b>FROSTBURG</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MINERS HOSPITAL</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>GOVERNMENT EMPLOYEE</b>			12b KIND OF BUSINESS OR INDUSTRY <b>TARIFF COMM.</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before adm'ssion) STATE <b>MARYLAND</b>			13b COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>FROSTBURG</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>260 E. MAIN ST.</b>		
14 FATHER'S NAME First <b>ROBERT</b>			Middle <b>J.</b>		Last <b>RUGE</b>		15 MOTHER'S MAIDEN NAME First <b>FRANCES</b>			Middle <b>SCHREIBER</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO <b>215-44-7932-T</b>		17. INFORMANT Address <b>ELIZABETH RUGE, FROSTBURG, MD. 21532</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1968</b> , to <b>July 1, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 1, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>G. Paige Strong</b>				DEGREE <b>E. PAIGE STRONG, M. D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/1/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>E. PAIGE STRONG, M. D.</b>				22e. ADDRESS <b>167 E. MAIN ST - FROSTBURG MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JULY 3 '68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAELS CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>JOSEPH R. DURST, FROSTBURG, MD. 21532</b>				25a. REC'D BY REGISTRAR <b>JUL - 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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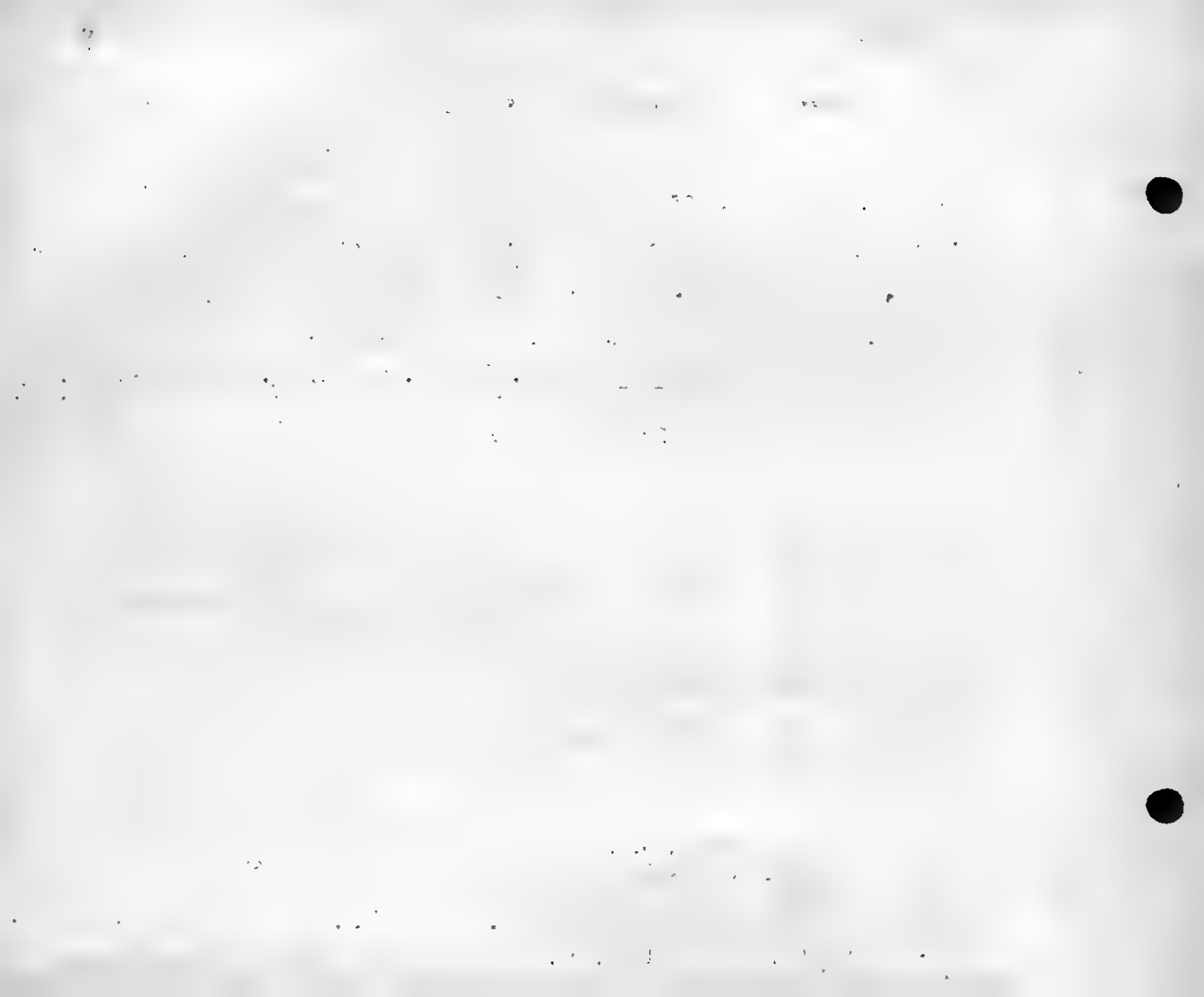
MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
<div style="text-align: right;">09322</div> <div style="text-align: center;">314</div> <div style="text-align: center;">CERTIFICATE OF DEATH</div>												
1. DECEASED-NAME (Type or print) First Middle Last MILTON RADER SAMPSON						2a. DATE OF DEATH Month Day Year JULY 14 1968			2b. HOUR 12:01 A			
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 13, 1901			6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.						
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Conductor			12b. KIND OF BUSINESS OR INDUSTRY RAILROAD			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WEST VA.			13b. COUNTY Mineral		13c. CITY OR TOWN SPRINGFIELD		13d. INS. DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. # 1 Dan Runs Road			
14 FATHER'S NAME First Middle Last CHARLES A. SAMPSON			15. MOTHER'S MAIDEN NAME First Middle Last GERTRUDE J. MARPLE									
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO 705-10-0937		17. INFORMANT Address HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE PHARYNGEAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF PHARYNX DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HRS. 1 YR		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1412												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from MAR 1, 1968 to JUL 13, 1968, that (I) (we) last saw the deceased alive on JULY 13 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Arthur S. Bauer M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED JULY 14, 1968				
22d. PHYSICIAN'S NAME (Type) ARTHUR S. BAUER, M.D.						22e. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/17/68		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		23d. LOCATION (City or Town) (County) (State) Fort Ashby Mineral W. Va.						
24. FUNERAL DIRECTOR H. Wayne George GEORGE'S FUNERAL HOME						ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JUL 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First <b>Emilie</b>	Middle <b>Catherine</b>	Last <b>SCHELL</b>	2a. DATE OF DEATH JULY Month 25 Day 68 Year			2b. HOUR A M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>FEBRUARY 26, 1886</b>		6. AGE (in years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY COUNTY</b> Md.				
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>HOUSEWIFE &amp; housework</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>LA VALE</b>		13d. INS-DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1001 WEIRES AVENUE</b>		
14. FATHER'S NAME First <b>HENRY</b>			Middle <b>SWAB</b>		15. MOTHER'S MAIDEN NAME First <b>CATHERINE</b>					Last <b>FIKE</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>171-07-8079</b>		17. INFORMANT <b>Mr. James H. Schell, Sr. 1007 Weires Ave. LaVale, Md.</b> PATIENT'S HOSPITAL CHART						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced Cirrhosis of the Liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Bronchial Pneumonia</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Clarence J. Vincent, M.D.</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/26/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>CLARENCE VINCENT, M.D.</b>		OR XXXXXXXX XXXX XXXXX, MD		22e. ADDRESS <b>126 N. SMALLWOOD ST., CUMBERLAND, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/27/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Locust Run Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>nr. Thompsonstown, Juniata Pa.</b>				
24. FUNERAL DIRECTOR <b>GEORGE FUNERAL HOME CUMBERLAND, MD. 21502</b> <b>H. Wayne George</b>				25a. REC'D BY REGISTRAR <b>JUL 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09324			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year		2b. HOUR		
Dorothy Donnell Scott						JULY 18 '68			9:00 a				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
Female		Black		10/27/1911		56 YRS							
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
Maryland				U S A				9. COUNTY OF DEATH					
Cumberland				Allegany				Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland				MEMORIAL HOSPITAL--DOA				Housewife				Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Allegany				Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		921 Maryland Ave.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Thomas NMI Washington				Mary Ellen Bromery									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT				ADDRESS	
No								Charles P. Scott				921 Maryland Ave, Cumberland Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION, LEFT													
4100 DUE TO, OR AS A CONSEQUENCE OF CORONARY THROMBOSIS													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
720 HYPERTENSIVE CARDIOVASCULAR DISEASE													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				JULY 18, 1968					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		7/22/1968		Woodlawn Cemetery		Cumberland Alleg Md.							
24. FUNERAL DIRECTOR <i>John J. Hafert, Jr.</i>				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
John J. Hafert, Jr., 230 Balto Ave. Cumberland Md				JUL 22 1968				<i>Charles Judge</i>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

09325

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A.M. P.M.	
William				Senkbeil	July 21, 1968		7:15 A.M.	
3. SEX	Male		4 RACE	White		5. DATE OF BIRTH	May 1, 1885	
6 AGE (In years last birthday)		83		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Cumberland, Md.		U. S. A.		Allegany County		Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland		Allegany County Infirmary		Retired Carpenter		Carpenter		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland		Allegany		Cumberland		505 Central Avenue		
14. FATHER'S NAME		First		Middle	Last	15. MOTHER'S MAIDEN NAME		
Charles		Senkbeil		Caroline		Klavuhn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		P.O. Box 599, Cumberland, Md. 21502		
		220-54-4185		JI Allegany County Infirmary records.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chr. A. S. H. D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u> <u>Many years</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4701								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from <u>Feb. 23, 1967</u> , to <u>July 21, 1968</u> , that (I) (we) lost saw the deceased alive on <u>July 20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (d not) view the body after death.								
22b. SIGNATURE <u>John A. Topper</u>		22c. DATE SIGNED 7-23-68		22d. PHYSICIAN'S NAME (Type) <u>John A. Topper</u>				
22e. ADDRESS <u>Memorial Hospital Cumberland, Md.</u>								
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		23b. DATE 7/24/68		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Luth. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Md</u>		
24. FUNERAL DIRECTOR <u>Louis Stein Inc. Cumb. Md.</u>		25a. REC'D BY REGISTRAR DATE JUL 25 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

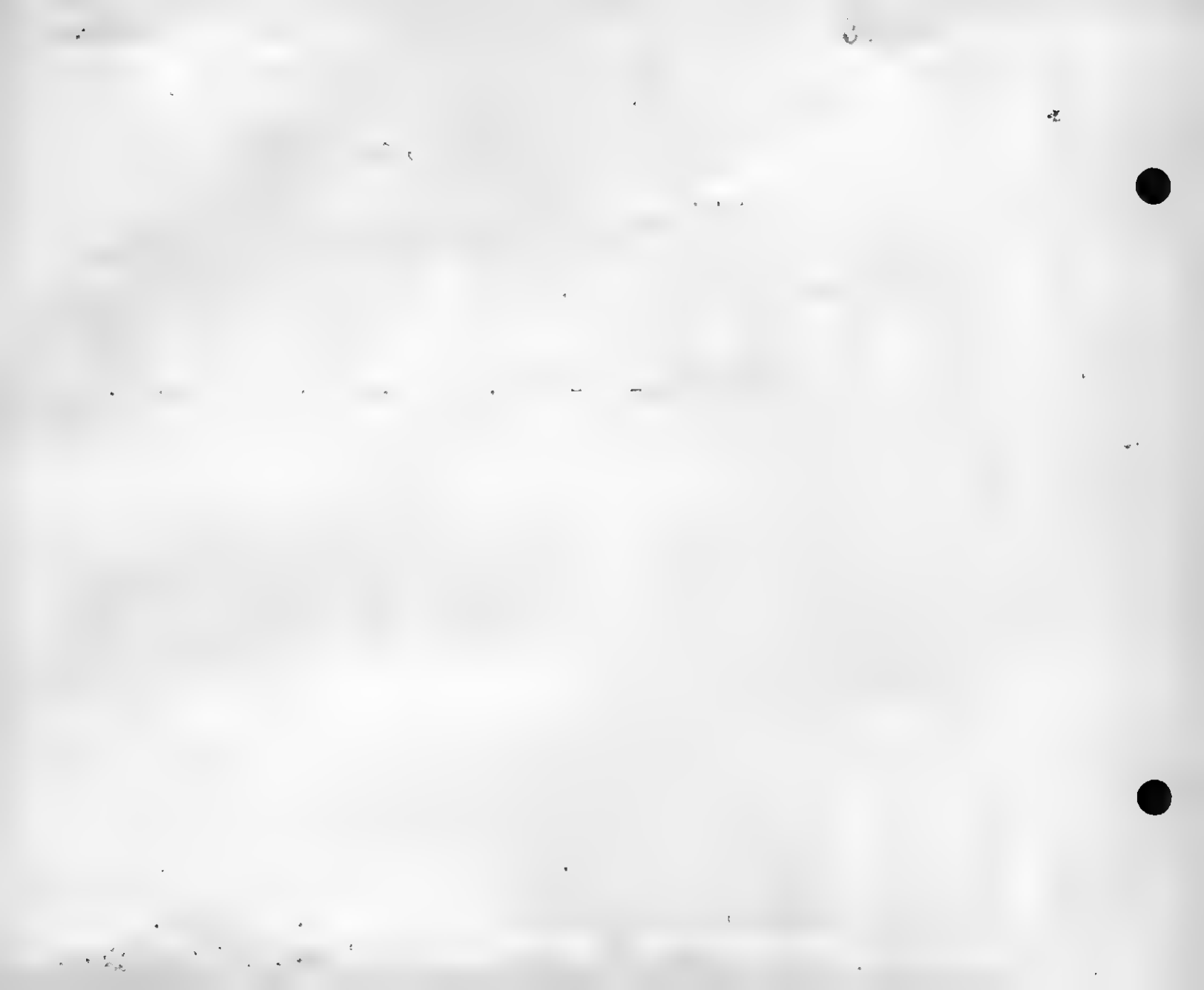


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First <b>HOWARD</b>	Middle <b>R.</b>	Last <b>SMITH</b>	2a. DATE OF DEATH Month <b>22</b> Day <b>1968</b> Year		2b. HOUR <b>5:20 AM</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MARCH 27, 1899</b>		6. AGE (In years last birthday) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN					
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>							
10. CITY OR TOWN OF DEATH <b>FROSTBURG</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MINERS HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED JANITOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE</b>							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>MT. SAVAGE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>FOUNDRY ROW</b>					
14. FATHER'S NAME First <b>JOHN</b>			Middle <b>SMITH</b>		Last <b>JOSEPHINE</b>		15. MOTHER'S MAIDEN NAME First <b>JOSEPHINE</b>			Middle <b>BENNETT</b>		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>712-14-2010-A</b>			17. INFORMANT Address <b>MRS. LAURA F. SMITH, MT. SAVAGE, MD.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>486x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1) Adrenal Cortex Insufficiency 2) Hypothyroidism</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'lly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 1966</b> to <b>7-22, 1968</b> , that (I) (we) lost saw the deceased alive on <b>7-22, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Martin Rothstein</b>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>7-22-68</b>							
22d. PHYSICIAN'S NAME (Type) <b>MARTIN ROTHSTEIN, M. D.</b>		22e. ADDRESS <b>48 BROADWAY, FROSTBURG, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JULY 24 '68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METHODIST CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>MT. SAVAGE, MD.</b>							
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, FROSTBURG, MD. 21532</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JUL 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days after death.

VR 113-4  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
09327											
1968 William H. Solomon											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
William H. Solomon						July 6 1968			11 P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		Sept 19 - 1893		74 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
Maryland		U.S.A.		NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegheny					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Cumberland Nursing Home			Retired			Lumberman		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Allegheny		La Vale				13 North Hardaway Ave		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
William T. Solomon			Emma Taylor								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			208-03-9547			Edward Solomon			519 Washington St		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CARCINOMATOSIS											
DUE TO, OR AS A CONSEQUENCE OF											
(b) PARCINOMA OF STOMACH											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year								
			P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION			City or Town County State		
						Street or R.F.D. No					
22a. I certify that (I) (this hospital) attended the deceased from Nov 1967, to JULY 1968, that (I) (we) last saw the deceased alive on JULY 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. I DID											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
L. M. Glick						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			7 JULY 68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
L. M. Glick M.D.						126 N. SMALLWOOD ST					
23a. BURIAL, CREMATION OR REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			7/9/1968			Hillcrest Burial Ph			Cumberland, Md.		
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
Louis Stein Inc. Cumb. Md.									JUL - 9 1968		
									25b. REGISTRAR'S SIGNATURE		
									Charles Judge		

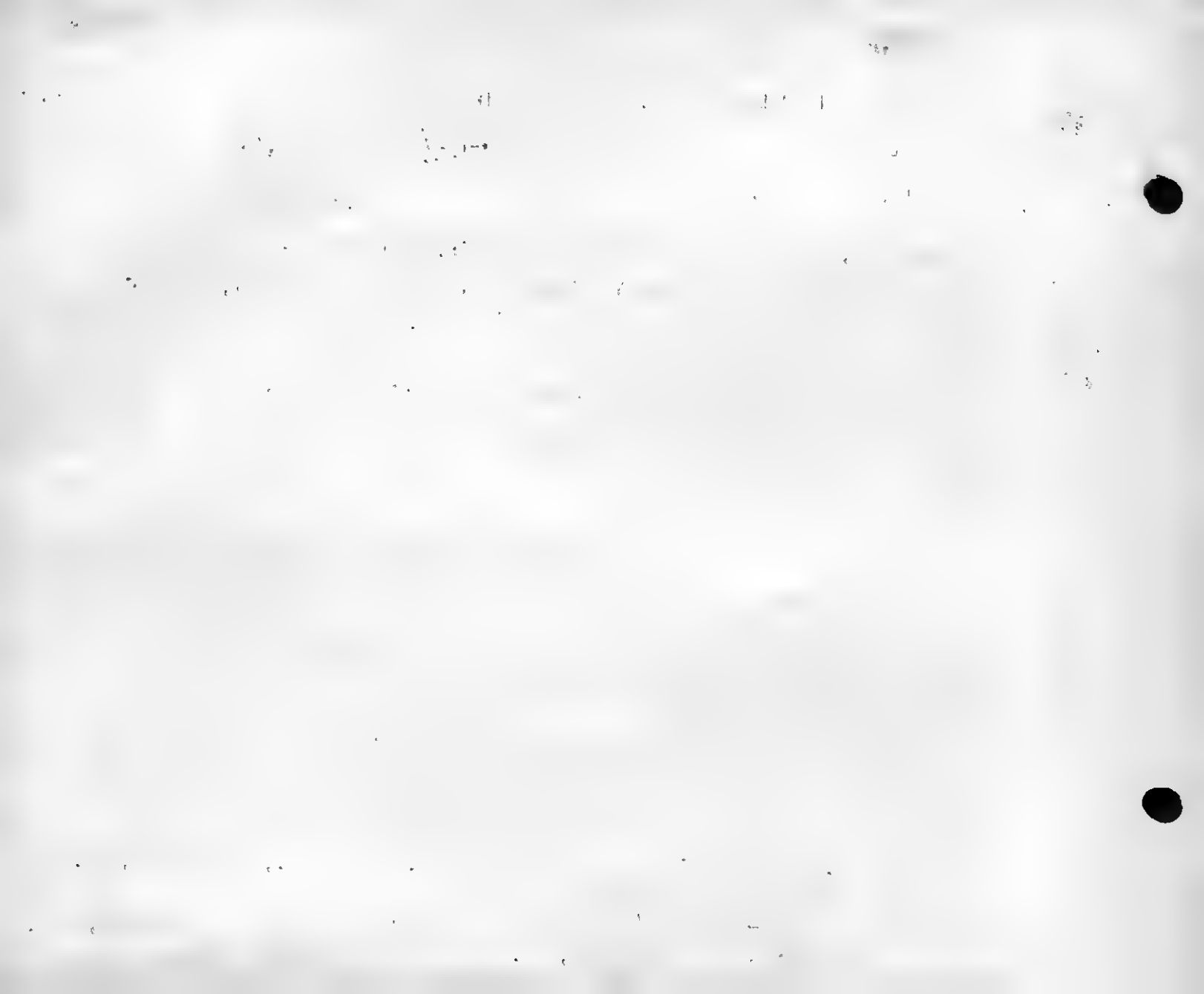
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	
ISABELL			E.		SPEIR		7		Month 20 Day 1968	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		8-1-87			78 YRS.		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND			USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			SACRED HEART HOSP.			HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		FROST		YES		ROUTE #1, BOX 165	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
JAMES STEVENSON			ELIZABETH MCFARLAND							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
			214-05-0607-B		GEORGE SPEIR, RT. 1, FROSTBURG, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Adenocarcinoma of rectum</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>2 years</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1968</u> to <u>July 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 20, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. Miltenberger</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) DR. MILTENBERGER					22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		7-23-68		F.B.G. MEMORIAL PARK		FROSTBURG, ALLEGANY, MD.				
24. FUNERAL DIRECTOR DURST FUNERAL HOME,				ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR JUL 26 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



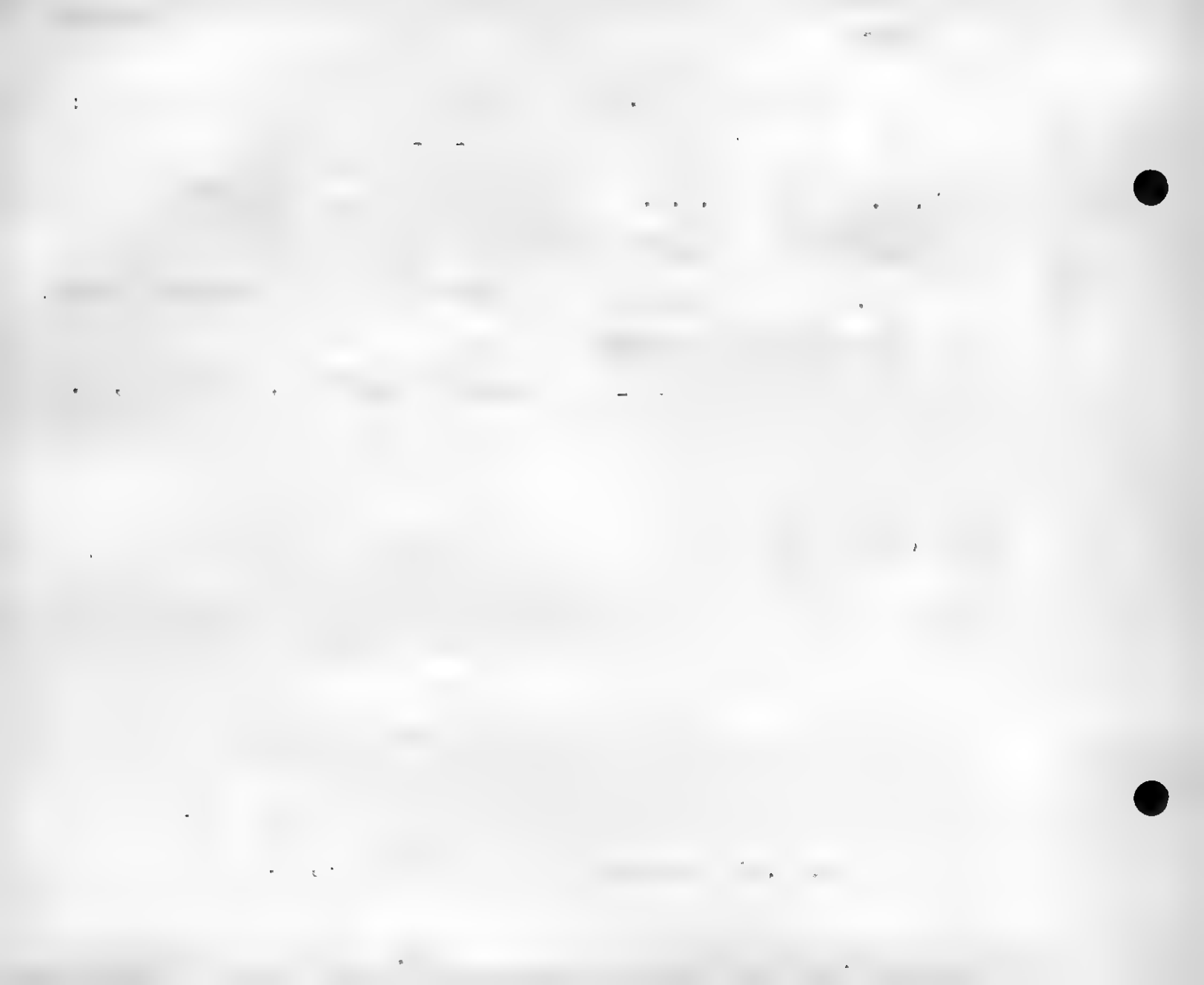


## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>CHARLES O. SPEROW</b>			2a. DATE OF DEATH Month <b>JULY</b> Day <b>10</b> Year <b>1968</b>			2b. HOUR <b>3:20PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>8-11-76</b>		6. AGE (In years last birthday) <b>91</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED ENGINEER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R R</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. HAS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>421 WAVERLY TERRACE</b>		14. FATHER'S NAME First Middle Last <b>CHARLES ORVAL SPEROW</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY ETTA HANN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO <b>705-10-0768</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction 1 day</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Marked pulmonary fibrosis</b>							
19a. DATE OF OPERATION <b>9 July 68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary stenosis</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from <b>19 June, 1968</b> , to <b>10 July, 1968</b> , that (1) (we) last saw the deceased alive on <b>10 July, 1968</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (do not) view the body after death.							
22b. SIGNATURE <b>Dr. F. Miltenberger</b>				22c. DATE SIGNED <b>11 July 68</b>		22d. PHYSICIAN'S NAME (Type) <b>DR. F. MILTENBERGER</b>	
22e. ADDRESS <b>CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (See IV) <b>Burial</b>		23b. DATE <b>7/13/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Cumberland Alleg Md.</b>	
24. FUNERAL DIRECTOR <b>Charles E. Hafer</b>				25a. REC'D BY REGISTRAR <b>MAUL 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 111 M  
304M REV. 1-66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
CATHERINE J. STANTON						Month	Day	Year	8 P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE		CAUCASTAN		MARCH 27, 1877		91 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		FROSTBURG				29 BEALL'S LANE	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MA DEN NAME			First Middle Last
PATRICK CONNELLEY						MARGARET BOYLAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
NO			215-48-6041-JI		MRS. LAVERN CROSS		29 BEALL'S LANE FRBG MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15+20 days</i>									
+109 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis of Coronary Arteries</i> <i>15+ yrs.</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>Generalized Arteriosclerosis</i> <i>20+ yrs.</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<i>7-15-68 Fracture Closed Subcapitulum - rt Hip</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
7-15-68		Fracture closed non-union		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year		P.M. 4 10 1968		Slipped & fell at home.			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION (Street or R.F.D. No. City or Town County State)					
		Home		29 Beall Lane Frostburg Allegany Maryland					
22a. I certify that (I) (this hospital) attended the deceased from 7/10, 1968, to 7/25, 1968, that (I) (we) saw the deceased alive on 7/24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
WILLIAM R. WOLVERTON MD									7/30/68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
WILLIAM R. WOLVERTON MD					108 HARRISON ST. CUMBERLAND, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		JULY 29, 1968		ST. MICHAEL'S CEMETERY		FROSTBURG ALLEGANY MD			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST SR.					FROSTBURG MD		AUG 1 1968		Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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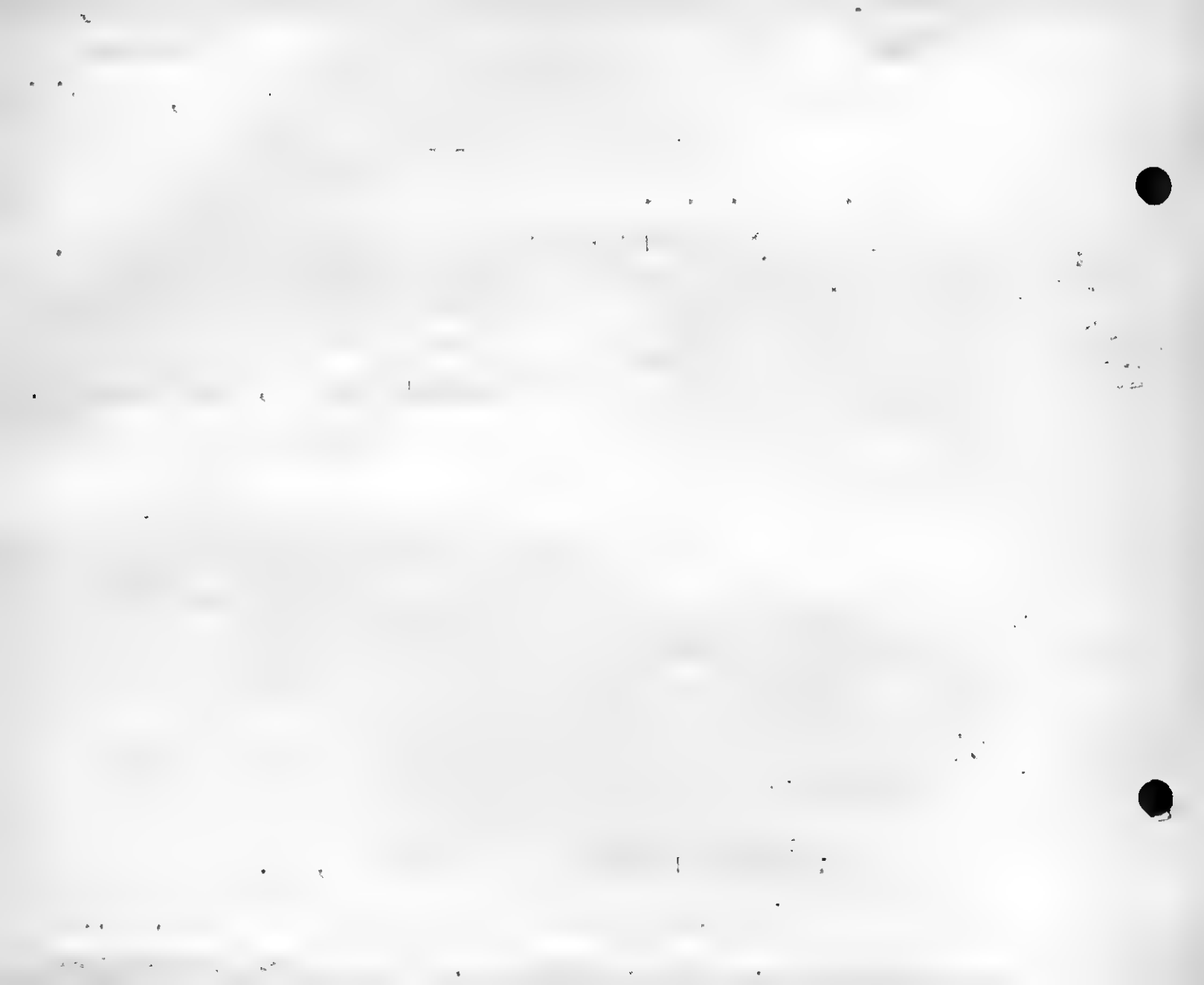
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)			First <b>LINDA</b>		Middle <b>GAIL</b>		Last <b>TICE</b>		2a. DATE OF DEATH Month <b>JULY</b> Day <b>22</b> Year <b>1968</b>		2b. HOUR <b>11:55</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>5-12-1957</b>			6. AGE (In years lost birthday) <b>11</b> YRS.		IF UNDER 1 YEAR MONTHS <b>11</b> DAYS <b>11</b>		IF UNDER 24 HRS. HOURS <b>11</b> MIN. <b>55</b>	
7a. BIRTHPLACE (State or foreign country) <b>TEXAS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>						
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>STUDENT</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>PENNA.</b>		13b. COUNTY <b>Bedford</b>		13c. CITY OR TOWN <b>EVERETT</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>30 WEST FOURTH STREET</b>				
14. FATHER'S NAME First <b>HAROLD</b> Middle <b>A</b> Last <b>TICE</b>			15. MOTHER'S MAIDEN NAME First <b>ZILPHIA</b> Middle <b>R.</b> Last <b>MASSEY</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5670 Retroperitoneal abscess</b>										<b>2 wk.</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pyelonephritis, Acute</b>										<b>2 wk.</b>		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>5768</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Post-operative meningomyelocele 10 yrs with partial paralysis lower extremities</b>												
19a. DATE OF OPERATION <b>July 19, 1968</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Retroperitoneal abscess</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>July 22, 1968</b> , to <b>July 23, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 22, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Ralph A. Reiter M.D.</b>						DEGREE <b>MD.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>July 23, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>DR. RALPH A. REITER</b>						22e. ADDRESS <b>112 BEDFORD ST., CUMBERLAND, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/25/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Union Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>W. Prov. Twp., Bedford Co., Pa.</b>				
24. FUNERAL DIRECTOR <b>Lynford V. Conner,</b>				ADDRESS <b>Everett, Pa.</b>		25a. REC'D BY REGISTRAR <b>JUL 26 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First <b>GILBERT</b>		Middle <b>A</b>		Last <b>TWIGG</b>		2a. DATE OF DEATH Month <b>JULY</b> Day <b>30</b> Year <b>1968</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>6-5-85</b>			6. AGE (In years last birthday) <b>83</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>			10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Engineer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>RRd.</b>			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>PA.</b> COUNTY <b>13b. CITY OR TOWN</b> <b>BEDFORD</b>		
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER			14. FATHER'S NAME First <b>Moses</b> Middle <b>Twigg</b> Last <b>Twigg</b>			15. MOTHER'S MAIDEN NAME First <b>Lizzie</b> Middle <b>Bender</b> Last <b>Bender</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>705-10-7052</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforation of Esophagus, Traumatic</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable Carcinoma of Cardiac End of Stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Uncertain</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>151x</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. N.JURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>July 30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Calvin Y. Hadidian M.D.</b>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) <b>DR. CALVIN Y. HADIDIAN</b>		22e. ADDRESS <b>CUMBERLAND, MD.</b>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>August 2, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Madley Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Buffalo Mills, Pa., RD#1</b>		24. FUNERAL DIRECTOR <b>Harvey H. Zeigler, Hyndman, Pa.</b>		
25a. REC'D BY REGISTRAR <b>DATE AUG 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jager</b>								



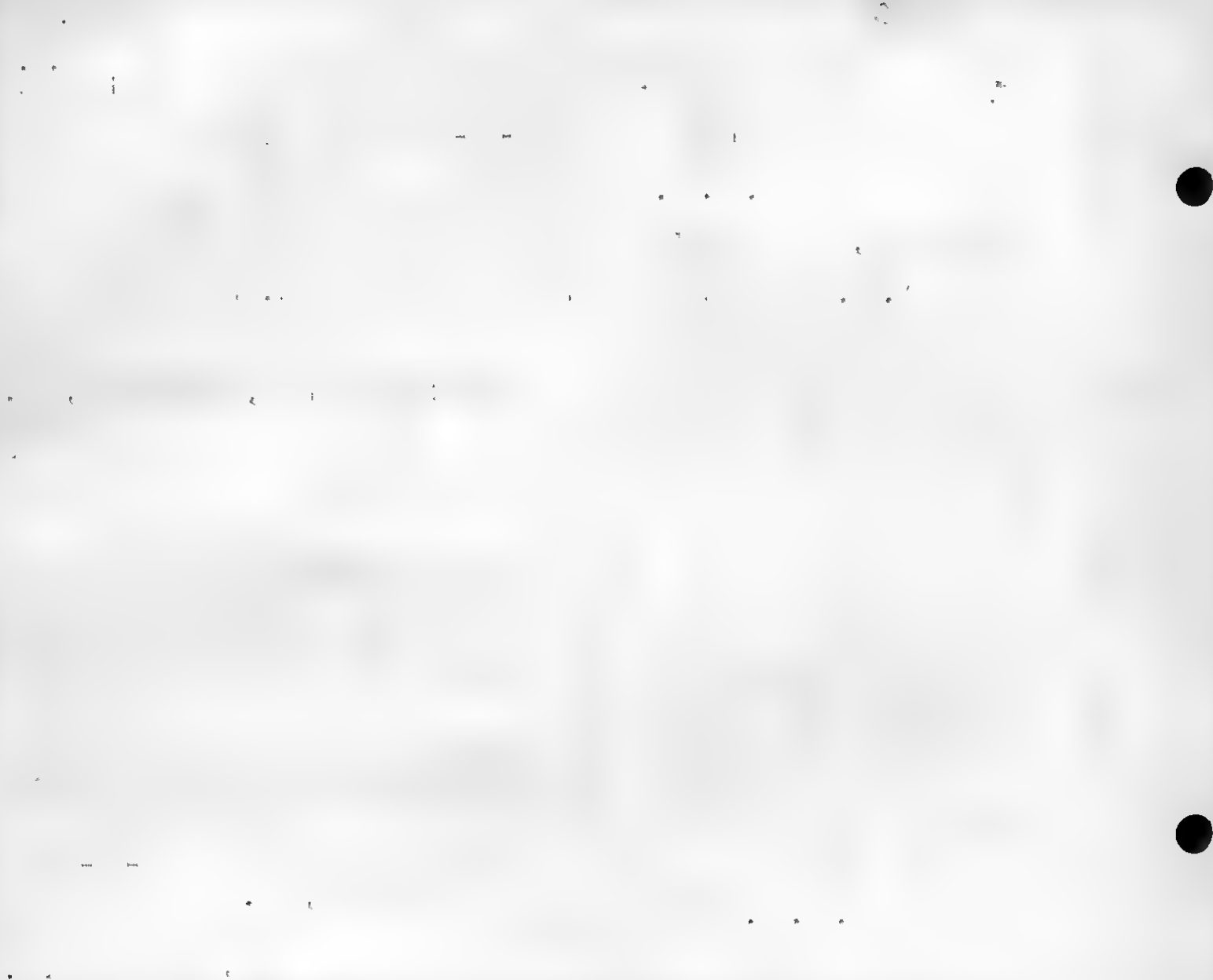


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.)

VR A15 (4)  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)		ZELLA		Middle M. TYSON		2a. DATE OF DEATH JULY Month 13 1968		P.M. HOUR 4:45	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 9-15-90		6. AGE (In years 77 birthday)		7. YRS. MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm-ssion) STATE W. VA.		13b. COUNTY MINERAL		13c. CITY OR TOWN RIDGELEY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RT. 1	
14. FATHER'S NAME First Middle Last George Weaver		15. MOTHER'S MAIDEN NAME First Middle Last Alioe Gross		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u> years: 4/24 3 weeks								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>  </u> , to <u>July 23, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 23, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22e. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/26/1968		23c. NAME OF CEMETERY OR CREMATORY Davis Cemetery		23d. LOCATION (City or Town) (County) (State) Davis, Tucker, W. Va.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09334									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		Month	Day	Year
		HALLIE	M.	VALENTINE			JULY	20	1968
3. SEX	FEMALE		4. RACE	WHITE		5. DATE OF BIRTH	6. AGE (In years last birthday)		7. YRS.
							12-5-1890		77
7a. BIRTHPLACE (State or foreign country)	MARYLAND		7b. CITIZEN OF WHAT COUNTRY?	U. S. A.		8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, or if retired)		HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN Home		
13a. USUAL RESIDENCE (Where deceased admission) STATE	MD.		13b. COUNTY	ALLEGANY		13c. CITY OR TOWN	CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER		1207 FREDERICK ST.							
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
		ISAAC		WILSON			JANE		ROBERTSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-05-6842		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Refractory Heart Failure									1 week
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease									years
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
4129									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		Street or R.F.D. No		City or Town
									County
									State
22a. I certify that (I) (this hospital) attended the deceased from Jan 1968, to July 20, 1968, that (I) (we) last saw the deceased alive on July 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			7-21-68				
22d. PHYSICIAN'S NAME (Type)		DR. W. P. JAMES			22e. ADDRESS		CUMBERLAND, MD.		
		C. OVERTON HUBBARD WRIGHT, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Jul. 23, 1968		Greenmount Cemetery		Cumberland Allegany Md			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William G. Kight		Cumberland, Md.		DATE JUL 24 1968		Charles Judge			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b HOUR a M
Mary Irene Wempe						OF EST. DEATH <input type="checkbox"/> 7-14-68 1912			30 a M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (n years st birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year	
Female	White	July 1, 1909	49 YRS					JULY 14, 1968 19 12:30 M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Allegany Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Cumberland			SACRED HEART HOSPITAL			Shipping Dept.			Tire
13a USJA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.			Allegany		Cumberland			614 Elwood St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Joseph B. Minnick			Frances L. Mc Kenzie						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
no					Raymond Wempe, Cumberland, Md. Husband				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC FAILURE WITH EDEMA DUE TO, OR AS A CONSEQUENCE OF 517X (b) COR PULMONALE (c) PULMONARY FIBROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS "
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 25X									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No		City or Town		County State
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			Benedict Skitarelic M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> JULY 14, 1968	
						ADDRESS (Street, city, town, or county)		CUMBERLAND, MARYLAND	
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		July 18, 1968		St. Mary's Cemetery		Cumberland Allegany, Md.			
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, Md.						DATE JUL 17 1968		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)  
15M 9/60

<b>MARYLAND STATE DEPARTMENT OF HEALTH</b> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b> <b>CERTIFICATE OF DEATH</b>									
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <b>Allegany County</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) <b>a. STATE</b> <b>Maryland</b>				
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>					<b>b. COUNTY</b> <b>Allegany County</b>				
<b>c. LENGTH OF STAY IN 1b</b> <b>Westernport</b>					<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>				
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <b>Reeve's Clinic</b>					<b>d. STREET ADDRESS</b> <b>110 Main Street</b>				
<b>3. NAME OF DECEASED</b> <b>(Type or print)</b> <b>Earl Richard Woy</b>					<b>4. DATE OF DEATH</b> <b>July 2 1968</b>				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>March 8, 1920</b>		<b>9. AGE (In years last birthday)</b> <b>48 yrs.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Paper Maker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>W.Va. P &amp; P Co.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Luke, Md. Allegany</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		<b>13. FATHER'S NAME</b> <b>Earl C. Woy</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Rachael Gross</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> <b>(Yes, no, or unknown)</b> <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217-05-9876</b>		<b>17. INFORMANT</b> <b>Mrs. Richard Woy</b>		<b>Address</b> <b>110 Main St West. Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>Acute Myocardial infarction</b> <b>IMMEDIATE CAUSE (a)</b> <b>4109 DUE TO Coronary sclerosis &amp; thrombosis</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,</b> <b>(b)</b> <b>(c)</b>									
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>4201</b>									
<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> <b>Hour</b> <b>a.m.</b> <b>p.m.</b>		<b>20d. INJURY OCCURRED</b> <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>	
<b>20g. (State)</b>		<b>21. I certify that (I) (this hospital) attended the deceased from July 2, 1968, to July 2, 1968, that (I) (we) last saw the deceased alive on July 2, 1968, and that death occurred at 9:45, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>J. Norman Reeves</b>					<b>22b. DATE SIGNED</b> <b>3 July 1968</b>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>J. Norman Reeves, M.D.</b>					<b>22d. ADDRESS</b> <b>Westernport, Md.</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>July 5, 1968</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Peter's Catho. Cem.</b>		<b>23d. LOCATION (City, town or county)</b> <b>Westernport Alleg. Md.</b>		<b>(State)</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Fredlock Jr</b>					<b>25. REC'D BY REGISTRAR</b> <b>JUL - 9 1968</b>				
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>									



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text is arranged in several paragraphs and includes some numbers and names, but is too light to transcribe accurately.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
WILLIAM WALLACE ZIMMERLY						JULY 31 1968		12:35	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		NOV 29, 1910		57 YEARS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
CUMB. MD.		USA				ALLEGANY		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		MEMORIAL HOSPITAL				GROCERY AND SERVICE STATION			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.		ALLEGANY		CUMBERLAND				ROUTE 4, OLDTOWN ROAD	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
GEORGE A. ZIMMERLY			MARY U. DAVIS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO		214-32-2928		MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Emphysema</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Right ventricular enlargement</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
5771									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> , 19 <u>68</u> , to <u>7/31</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>DR. R. J. WILLIAMS</u>		7/31/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
DR. R. J. WILLIAMS		122 S. CENTRE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		AUGUST 2 1968		DAVIS MEMORIAL PARK		RFD 4 CUMBERLAND ALLEGANY MD.			
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
H. LEE SILCOX 404 DECATUR ST CUMBERLAND, MD.				AUG 2 1968		<u>Charles Judge</u>			

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JULY 31 1968

STANLEY

WILLIAM

WHITE

WALK

ALBANY

USA

CL. 7. 7. 10

WEIDING HOSPITAL

CLEVELAND

X ROUTE 2, GLENVIEW ROAD

CONFERENT

ALLEGANY

NO.

DAVIS

STANLEY

GEORGE

WEIDING HOSPITAL, CLEVELAND, OH.

DR. R. J. WILLIAMS

122 S. CLEVELAND ST., CLEVELAND, OH.

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